SCOTTSDALE
EYE PHYSICIANS & SURGEONS, PC

Dennis L Kilpatrick, MD
Candria E Meharry, OD

Personal Information

(Please Print Clearly)

Today's Date _____

Name _____ Social Security Number _____

Date of Birth _____ ○ Male ○ Female

Street Address _____

_____

City, State, Zip _____

Employer Name _____

Occupation (or previous, if retired) _____

Phone Numbers

Cell _____

Home _____

Work _____

Email _____

Responsible Party _____ ○ Self ○ Other:

Street Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____

Employer Name _____

Insurance Policy Holder _____

Primary Insurance Company, Plan Name _____

ID # _____ Group # _____

Secondary Insurance Carrier

ID # _____ Group # _____

○ Spouse or ○ Parent Name _____

Other family members seen in our office _____

_____

Relative not at your address _____

Street Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____

How did you hear about our office? ○ Yellow Pages ○ Friend ○ Family Member ○ Website

○ Another patient, who? _____

○ Another doctor, who? _____

○ Hospital, which? _____

○ Letter/Advertisement? _____ (Please Turn This Page Over)

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Conditions for Treatment and Collection of Payment

I HEREBY AUTHORIZE Scottsdale Eye Physicians & Surgeons, P.C. to examine and treat me or the individual for whom I am responsible. If I am receiving a "vision exam" only, I understand that this is not a comprehensive eye examination for eye diseases.

During the course of diagnosis or treatment, eye drops may be used to dilate the pupils. These drops may cause blurred vision and glare for several hours. I understand that driving an automobile or operating machinery is not advised until the effects of the drops have worn off.

I understand that it is my responsibility to obtain prior authorization for my visit with the Doctors if required by my insurance plan. I understand that I have the primary responsibility for payment of my charges unless the Doctors have a contract with my insurance plan that prohibits them from billing me directly for "covered" services. Some services performed by Scottsdale Eye Physicians & Surgeons, P.C., such as after-hours services, some tests, and refractions (checking for glasses), may not be "covered" or reimbursed by my insurance company. I understand I will be responsible for payment of any of the following: "non-covered" services, co-payments, unmet deductible amounts, collection fees, if appropriate authorization was not obtained from my insurance company prior to the examination, and if I am no longer covered by the insurance plan I listed.

Over due balances over 90 days from the date of service will accrue a charge of 1.5% interest per month on the total balance for amounts greater than $500. Overdue balances over 90 days for balances under $500 will be charged $15 rebilling fee per month.

Scottsdale Eye Physicians & Surgeons, P.C. is required to submit a completed insurance form to Medicare and some insurance plans. Insurance guidelines permit them to obtain a one-time signature that is valid for this and future visits to their office. I understand that by signing below, the notation "SIGNATURE ON FILE" will appear in lieu of my signature on Medicare and other insurance claim forms submitted for me by this office.

I authorize Scottsdale Eye Physicians & Surgeons, P.C. to release information acquired in the course of my examination and treatment to my insurance carriers and other medical providers.

Signature of patient (or guardian) _____

Printed name of patient _____

Date _____