Clarity
EYE CARE & SURGERY

New Patient Information

Date_____

Name (Last, First, Initial):_____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ Cell Phone: _____ Home Phone: _____

Email Address: _____ ☐ I want access to the Patient Portal. Please send me online credentials.

Patient Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Birthdate: _____ Sex: _____ Social Security#: _____

Emergency Contact: _____ Phone: _____

Referred by:_____ Primary Care Doctor: _____

Primary Insurance: _____ Policy No: _____

Secondary Insurance: _____ Policy No: _____

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student

Employer's Name: _____ Phone: _____

Your Preferred Pharmacy: _____ Nearest Cross-Street: _____

Refraction Fee:
A refraction is the test done to determine your eyeglass prescription***. Most medical insurance plans, including Medicare do not cover this service.*** The refraction is not a medical service, it is a routine service.

We will be happy to perform the refraction on any patient requesting the service; however, there will be a **$48.00 charge** that you the patient will be responsible for.

The choice to have the refraction done is yours. If you feel you are not seeing as well as you used to, if things seem blurry or if you want to update your lenses or frames it is advised that you choose to have the refraction performed.

If you decide against having the refraction done, your decision will in no way affect the medical portion of your exam.

Please select one of the options below and initial next to your choice: Please Initial

☐ Yes, I would like to have a refraction done today. _____
☐ No, I do not want the refraction done today. _____
☐ I am unable to have the refraction done today, but would like to have it done at my next visit. _____

Receipt of Notice of Privacy Practices Acknowledgment
I acknowledge that I have received the Notice of Privacy Practices from Kristin Carter, M.D., which sets forth the ways in which my personal health information may be used or disclosed by Kristin Carter, M.D., and outlines my rights with respect to such information.

Patient's Signature: _____ Date: _____

I will be assessed a $25.00 charge if I fail to show for my appointment or do not give 24 hour notice prior to cancelling my appointment.

Assignment of benefits, financial responsibility, and release of information:
I hereby assign my insurance benefits to be paid directly to Kristin Carter, M.D. **I am financially responsible for non-covered services. I understand and agree that if I do not pay my account in a timely fashion and collection steps become necessary, I will be responsible for all collection costs including, but not limited to, attorney fees and court costs.** I also authorize the office of Kristin Carter, M.D. to release any information required to process this claim.

Patient's Signature: _____ Date: _____