



Phone: (208) 667-2531

Fax: (208) 765-9385

www.northidahoeeye.com

PATIENT INFORMATION

Patient ID# _____

Patient's Name: _____ Date of Birth: _____ Age: _____

First Initial Last

Social Security #: _____ Sex: []M []F Marital Status: []Married []Single []Divorced []Widowed

Mailing Address: _____ City: _____ State: ID Zip: _____

E-mail Address: _____ County: _____

Home Phone: _____ Cell Phone: _____ Preferred: Home Cell

I **do not** want text messages for appointment reminders sent to my cell phone number listed above.

Race: [] White [] American Indian or Alaska Native [] Pacific Islander [] Black or African American [] Asian Other Race: _____

Ethnicity: [] Hispanic [] Non-Hispanic or Latino [] Decline Language: _____

Occupation: _____ Employer: _____ Phone: _____

Referring Physician: _____ Personal/Family Physician: _____

EMERGENCY CONTACT

Name: _____

Phone: _____ Relationship: _____

Preferred Pharmacy: _____ City: _____

Responsible Party Information

Same as patient information listed above.

Responsible Party:		Patient Relationship:
Date of Birth:		Social Security #:
Address:		City, State, Zip: _____ , _____
Employer:		Phone: _____

PRIMARY INSURANCE

SECONDARY INSURANCE

Insurance Name:		Insurance Name:	
ID Number:		ID Number:	
Group Number:		Group Number:	
Subscriber Name:		Subscriber Name:	
Date of Birth:		Date of Birth:	

Person(s) with who(m) we may share your healthcare information: *(If left blank, we will not share any patient information)*

Name: _____ Date of birth: _____

Name/Facility: _____ Date of birth: _____

I hereby certify that the above information is true and accurate to the best of my knowledge.

Patient/Responsible Party Signature: X _____ **Date:** _____

****MORE ON BACK****

Insurance Authorization Agreement

I authorize North Idaho Eye Institute, North Idaho Cataract and Laser Center, and/or Coeur d'Alene Optical to provide any applicable personal or medical health care information contained in my records for treatment, account balance resolution, and other healthcare operations to appropriate agencies, including collections agencies, insurance companies and third-party payers.

I authorize treatment of the person named above, I certify that I am the patient or legal guardian of the and agree to pay all fees and charges for such treatment. I agree to pay all charges shown by statements promptly unless payment arrangements are made. I understand that I am responsible for all charges regardless of insurance coverage, and all proceeds of insurance are assigned to this office where applicable.

Insurance and Financial Statement

North Idaho Eye Institute and North Idaho Cataract & Laser Center all accept Medicare, Medicaid as well as many commercial insurances. If you do not have insurance, or a secondary insurance that covers your deductible and/or coinsurance, you will be expected to pay your copay and/or coinsurance at the time of service.

Refractions are not covered by Medicare and may not be covered by your insurance. You are responsible for the refraction charge of \$45.00 and is due at the time of service.

It is the patient's responsibility to ensure that appropriate referral information from the insurance company is sent to our office before your visit. If referral is not present at the time of service, you may be asked to re-schedule.

Idaho Medicaid does not provide routine vision care to patients over the age of 21. By signing below, you agree to and understand that you will be financially responsible for routine vision care provided.

If you have any questions, or need to set up payment arrangements please contact our business office at 208-667-5540. I hereby certify that I have read the above agreement and statement and agree to adhere to the terms above.

I have reviewed the above policies and information and verify that the information I provided is the correct information to the best of my knowledge.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of Provider's Notices of Privacy Practices with the effective date of 02/17/2021.

Patient printed name: _____

Patient signature: _____ **Date:** _____

Employee Initials: _____

Form updated: 03/04/2022