Check the box beside the doctor you are seeing.

- ☐ *Karren Laird Russo*, M.D.
- ☐ *T. Chadwick Norton*, M.D.
- ☐ *Bernard E. Patty III*, M.D.
- ☐ *Michael Redmond*, M.D.
- ☐ *Eric Reish*, M.D.
- ☐ *Richard Walters*, O.D.
- ☐ *Bryan Jeanfreau*, O.D.
- ☐ *Kayla Gaddis*, O.D.

PATIENT INFORMATION

Date

First Name ______ MI ______ Last Name ______

Address ______ City ______ State ______ Zip ______

Social Security # ______ Date of Birth ______ Age ______

Home Phone ______ Daytime/Work Phone ______ Cell Phone ______

Email Address ______ Occupation ______

❑ Male ❑ Female ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Minor

Date of Accident ______ Is an attorney involved? ❑ Yes ❑ No If yes, attorney name ______

Is this visit related to a car accident? ❑ Yes ❑ No Is this visit related to a work injury? ❑ Yes ❑ No

Where did the accident occur? ______

Did a physician refer you to Alexandria Eye & Laser? ❑ Yes ❑ No

If yes, name of the physician, address and phone number: ______

Emergency contact ______ Phone ______

Guardian/Parent (If patient is under 18)

First Name ______ MI ______ Last Name ______

Address ______ City ______ State ______ Zip ______

Social Security # ______ Date of Birth ______ Relationship ______

Home Phone ______ Daytime/Work Phone ______ Cell Phone ______

Party responsible for Payment ❑ Self ❑ Other Name ______

Address ______

INSURANCE INFORMATION

Name of Insured ______ Relationship to Patient ______

Birthdate of Insured ______ Social Security # ______

Name of Employer ______ Work Phone ______

Employer Address ______ City ______ State ______ Zip ______

Insurance Company ______ Group# ______ Policy# ______

Insurance Co. Address ______ State ______ Zip ______

Name of Insured ______ Relationship to Patient ______

Birthdate of Insured ______ Social Security # ______

Name of Employer ______ Work Phone ______

Employer Address ______ City ______ State ______ Zip ______

Insurance Company ______ Group# ______ Policy# ______

Insurance Co. Address ______ State ______ Zip ______

AUTHORIZATION & ACKNOWLEDGEMENT

MEDICAL AUTHORIZATIONS AND RELEASE OF INFORMATION

I hereby authorize Alexandria Eye & Laser Center to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expenses relative to the services performed. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible for all charges, I hereby authorized Alexandria Eye & Laser Center to provide such medical services including surgery, if necessary, either regular or emergency, as may be determined to be in the best interest of the patient listed above. This authorization shall continue and remain effective until revoked in writing by me.

Signature ______________________________ Date ______________

AUTHORIZATION FOR RELEASE OF INFORMATION

The signature below serves as authorization for Alexandria Eye & Laser Center to release or receive medical information for the purpose of patient referral. A copy of this signature is as valid as the original.

Signature ______________________________ Date ______________

ACKNOWLEDGEMENT

Refraction is the process of determining the eye's refractive error, or need for corrective spectacle and/or contact lenses. It is an essential part of an eye examination, but is not a covered service by Medicare or most insurances. A fee for the refraction will collected in addition to any co-payment or deductible.

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The co-payment is separate from and not included in the refraction fee.

Signature ______________________________ Date ______________

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have reviewed the Alexandria Eye & Laser Center Privacy Practice Notice that describes how information about me may be used and disclosed. At my request, I can receive a copy of this notice.

Signature ______________________________ Date ______________

LIST ANY PERSONS TO WHOM YOU WILL ALLOW ACCESS OF YOUR MEDICAL RECORDS

Name ______________________________ Relationship to Patient ______________

Name ______________________________ Relationship to Patient ______________