Atchison Eye Center / Franken Eye Clinic
Dr. Christopher Franken
Atchison, KS 66002
Patient Information Sheet

Today's Date ____-____-____

First Name: _____ M.I. _____ Last Name: _____

Address: _____City/State/Zip: _____

SSN# _____-____-_____ Circle One: Male / Female Single / Married Date of Birth: ____-____-____

Home Phone: (____) _____-_____ Day Phone (____) ____-_____ Cell (____) ____-_____

Employer: _____Occupation: _____ Work Phone (____) ____-_____

Emergency Contact Person_____ Relationship_____ Phone (____) ____-_____

How would you prefer to be contacted? (Circle One) **E-mail** **Text** **Phone Call**

If e-mail, please provide e-mail address: _____

Person Responsible for account (Primary Insurance Holder)

Name: _____ Relationship_____ Male / Female

Address: _____City/State/Zip_____ Date of Birth ____-____-____

SSN# ____-_____-_____ Employer: _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____ Cell (_____) _____-_____

Due to Medicare and other insurance requirements, the following policy will be effective 09/01/06

Patient Responsibility

Refraction Charge

During your exam Dr. Franken may perform a refraction. The refraction is a test done to determine a prescription for new glasses. Refractions are not typically a covered expense by insurance companies. Medicare considers refractions as not "medically necessary" and therefore is not a covered charge. Your insurance company may not consider refractions medically necessary either. The cost of the refraction is **$55.00**.

Financial Waiver

In the event I do not have any insurance, my deductible has not been met, my insurance company does not pay in full or denies payment, I understand that I (Patient or Responsible Party) will be liable for all charges incurred. I understand if I do not have any insurance, my charges will be due and payable at the time of service.

Contact Lens Exam Cost

There is and additional charge for the contact lens examination. Most insurance companies do not cover contact lens related office visits. I understand these charges will be my responsibility. Initial contact lens exam is **$120-$150**. Subsequent year's exams range **$75-$100** depending upon the level of care necessary.

Direct Payment and Medical Release Authorization

I authorize Medicare/Medigap/Insurance to pay benefits directly to the Atchison Eye Center for any services or material furnished. I authorize release of medical information needed to process my claims or to determine benefits to the Centers for Medicare and Medicaid Services (CMS) and its agents. Furthermore, I authorize Medicare/Medigap/Insurance to furnish to this office any information regarding my claims under Title VIII of the Social Security Act. A copy of this signature is as valid as the original.

Signature: _____Date: _____