DOTHAN EYECARE

Brent McKinley, M.D.

Patient Name:______________________________ Date:______________

Date of Birth: ____________________ Age: __________ Sex: ❑ Male ❑ Female

Race: ❑ White ❑ African American/Black ❑ Hispanic ❑ Asian ❑ Other Race

Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Non-Latino ❑ Other ________ ❑ Declined ❑ Other Race

❑ English ❑ Spanish ❑ Japanese ❑ Other ❑ Declined

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced Religion: ______________

Patient's Address: ______________________________ **SS#** ______________

Physical Address: ______________________________

City, State, Zip Code: ______________________________

Home Phone # ____________________ Cell Phone # ____________________

Preferred Communication: ❑ Phone ❑ Email ❑ Text ❑ Declined

Patient's Employer: ____________________ Work Phone # ____________________

Employer's Address: ______________________________

If you are married, please complete the following:

Spouse's Name: ______________________________

Spouse's Date Of Birth: ____________________ Spouse's SS# ____________________

For insurance purposes

Spouse's Employer: ______________________________

Work Phone # ____________________ Cell Phone # ____________________

If you are a minor, please complete the following:

	Mother	**Father**
Guardian's Name:		
Guardian's SS#:		
Guardian's Date of Birth:		

IN CASE OF EMERGENCY CONTACT: (OTHER THAN SPOUSE)

Name: ______________________________ Phone# ____________________

DOTHAN EYECARE

Brent McKinley, M.D.

102 Doctors Drive, Suite 2 / Dothan, Alabama 36301
334-479-0043/ Fax# 334-479-0048

MEDICARE ASSIGNMENT
STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS OF PROVIDER

(Extended Payment Request for Physician Services Applicable to Current and future Treatment)

Name of Beneficiary: ______________________________ HIC# ____________________

I certify that the information given by me in applying for payment under Title XVlll of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made either to me or on behalf to Brent McKinley, M.D., and/or any of its physician employees, for any services furnished me by or in the name of such providers. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services. I recognize that this one-time authorization will permit Brent McKinley, M.D., and/or any of its physician employees, to submit any Medicare Claim, on either an assigned or an unassigned basis,without obtaining any additional signature from me, and will remain in the files of Brent McKinley, M.D., or for inspection by the Medicare carrier, and will continue in full force and effect unless cancelled by request.

Date: ____________________ Beneficiary: ______________________________

NOTICE OF POSSIBLE NON-COVERED EXAMINATION BY MEDICARE

Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1962(a)(1) of Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. I have been notified by my physician that he or she believes that, in my case, Medicare is likely to deny payment for the services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Date of Exam: ____________________ Beneficiary Signature: ______________________________

A. LIMBAL RELAXING INCISIONS / B. COSMETIC SURGERY (BLEPHAROPLASTY/LID)
C. DELUXE IMPLANTS / D.KERATOCONUS CONTACT LENSES / E. OPTICAL PRODUCTS (GLASSES & CONTACT LENS)

NON-COVERED PMD SERVICES

As our patient, we want to provide you with the best care possible. There may be certain services which we feel are necessary for the maintenance of good health that will not be covered by your Blue Cross Blue Shield of Alabama PreferredCare contract. **You will be expected to pay for any non-covered services. Please be assured that we will order only those test and perform only those services that are necessary for your treatment and care.**

We are aware of the following non-covered services:

A. LIMBAL RELAXING INCISIONS / B. COSMETIC SURGERY (BLEPHAROPLASTY/LID)
C. DELUXE IMPLANTS / D.KERATOCONUS CONTACT LENSES / E. OPTICAL PRODUCTS (GLASSES&CONTACT LENS)

Date: ______________ Procedure: ______________________________ Signature: ______________

Date: ______________ Procedure: ______________________________ Signature: ______________

Date: ______________ Procedure: ______________________________ Signature: ______________

Date: ______________ Procedure: ______________________________ Signature: ______________

USBPi REORDER #13351 (REV. 06/13)