Steven D. Zelko, M.D., Inc.
1933 Cliff Drive Suite 29
Santa Barbara, CA 93109

PATIENT INFORMATION

PLEASE PRINT, SIGN PAGE 2, AND BRING TO YOUR APPOINTMENT

******Co-payments and known deductibles are due at the time of service******

PATIENT NAME _____
(Mr, Mrs, Ms, Miss, Dr) (First Name) (MI) (Last Name) (Suffix)

MARITAL STATUS Married ☐ Single ☐ Other ☐ SEX M ☐ F ☐
REQUIRED FOR INSURANCE

PATIENT'S PERMANENT ADDRESS_____

CITY_____ STATE_____ ZIP_____

EMAIL (PLEASE PRINT CLEARLY)_____
See other side for information regarding Email and text message use

PHONE # (CELL)_____ (HOME)_____(WORK, OPTIONAL)_____

RACE: White ○ Hispanic ○ Asian ○ Black ○ Native American ○ Pacific Islander ○ Other ○ 2 or More ○ DECLINE ○

PRIMARY LANGUAGE: _____

PATIENT DATE OF BIRTH_____ SOCIAL SECURITY #_____
This may become necessary for determining insurance coverage

EMPLOYER_____ WORK ADDRESS_____

EMERGENCY CONTACT:

NAME_____ PHONE_____ RELATIONSHIP_____

PRIMARY CARE DOCTOR_____ CITY,STATE_____
Doctor's full name

REFERRED BY: _____

*****THIS PART REQUIRED FOR ALL STUDENTS:*****

PARENT/ RESPONSIBLE PARTY _____ Mother ○ Father ○ Other _____

FULL PERMANENT ADDRESS OF RESPONSIBLE PARTY:

_____PHONE_____

PLEASE VERIFY PRIMARY INSURANCE:

COMPANY_____ **SUBSCRIBER: SELF ○ SPOUSE ○ PARENT ○ Other ○**

SUBSCRIBER'S NAME IF OTHER THAN THE PATIENT_____

Subscriber's Birth Date:_____.

COMPLETE OTHER SIDE ⇨

ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR TREATMENT:

I hereby authorize treatment and authorize Dr. Zelko to release information pertinent to my case to and from any physicians, insurance company, adjuster, or attorneys involved in my care. I further authorize that payment of benefits be made to Dr. Zelko on my behalf. **I understand that I am financially responsible for all charges not covered by insurance. *Cancellations within 24 hours and no-shows may incur a $30.00 fee*.** The office of Steven D. Zelko, M.D.,Inc. reserves the right to terminate the relationship for multiple no-shows or non-payment of patient balance.

X Signed: _____ Date:

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES" (HIPAA) and CONSENT TO ELECTRONIC COMMUNICATION

I hereby acknowledge that I have been given the opportunity to read a copy of Dr. Zelko's "NOTICE OF PRIVACY PRACTICES," located in the reception area. By signing here and providing an email address and/or cell number, I give my consent and opt in to these electronic patient communication methods. We use email as our primary method of appointment confirmations and as a last resort method of other patient contact.

X Signed _____ Date:

ADVANCE BENEFIT NOTIFICATION

Most health insurance companies, including Medicare, **do not** pay benefits for *purely routine vision* eye examinations or refractions. We do not send Vision Insurance claims, but we will bill Medical Insurance Plans for a "Medical Eye Exam". Alternatively, you are welcome to pay at the time of service and send our receipt for vision plan reimbursement. We believe that refraction is an important part of the continuing health care of the eyes, **and** it is required to generate a prescription for eyewear. Therefore, we will collect our current fee and perform a refraction during our eye examination visit ***unless otherwise notified***.

I HEREBY ACKNOWLEDGE THAT I HAVE A CHOICE WHETHER TO INCLUDE A REFRACTION AS PART OF MY EYE EXAMINATIONS. I UNDERSTAND THAT A REFRACTION WILL BE PERFORMED DURING MY EYE EXAM UNLESS I NOTIFY DR ZELKOS STAFF THAT I DO NOT WANT A REFRACTION OR A PRESCRIPTION FOR EYEWEAR.

X Signed _____ Date:

NOTICE AND ACKNOWLEDGEMENT OF RECEIPT AND UNDERSTANDING (required by the State of Ca)

Medical doctors are licensed and regulated by the Medical Board of California. To check up on a license or to file a complaint, go to www.mbc.ca.gov or call (800) 633-2322.

X Signed _____ Date:

If not signed by the patient, Print Name_____

Please indicate Relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator
- ☐ Other _____