

PATIENT INFORMATION SHEET

Mr. Mrs. Ms. _____

Address: _____
Last Name First Middle Initial Parent/Guardian/Other

Home Phone: () _____ Date of Birth: / / Age: SS#: _____
Street City State Zip

Cell Phone: () _____ Email address: _____

How did you learn about our practice? _____ Medical Doctor/City: _____

Employer: _____ Business Address: _____

Occupation: _____ Business Phone: () _____

Marital Status (circle): M / S / Div. / Wid. / Partner If Married, Name of Spouse/Partner: _____

Spouse/Partner's Employer: _____ Spouse/Partner's Business Phone: () _____

Spouse/Partner's Business Address: _____

Payment information for first visit: 0 Check 0 Cash 0 Credit Card 0 Insurance

Primary Ins. Co./Mailing Address: _____

Name of Insured: _____

SS#: _____ Date of Birth: / / Member ID# Group ID#

Relationship to Insured: _____
Secondary Ins. Co./Mailing Address: _____

Name of Insured: _____

SS#: _____ Date of Birth: / / Member ID# Group ID#

Relationship to Insured: _____

Name of nearest relative not living with patient/responsible party: _____

Address: _____ Phone Number: () _____

Our goal is to provide you with the best medical care available. In order to achieve our goal and minimize escalating administrative costs, we ask for your understanding and cooperation regarding the following payment/insurance policies:

- 1. We ask that payments be made at the time of your visit unless other arrangements have been made in advance.
- 2. If you are a member of an HMO or POS plan, you need to have a VALID referral for each office visit and surgical procedure. Please call our office in advance to make sure you have the necessary forms and authorization.
- 3. It is our policy to render periodic statements for services on a monthly basis. In the event our statements for services are not paid within sixty (60) days after you receive an invoice, we reserve the right, at our option, to charge interest on the balance due, at a rate of one-and-one-half (1-1/2%) percent each month.
- 4. Our payment policy also requires that payments for refraction are expected at the time of service for all Medicare patients as well as for those patients whose insurance does not cover refraction.

Non-Medicare patients:

I hereby authorize payment directly to Associates in Eyecare, P.C. of the surgical and/or medical benefits, if any, otherwise payable to me for services as rendered. I authorize the physician to release such medical or other information regarding this treatment or subsequent treatment relative to this injury or illness for the purpose of obtaining reimbursement on my behalf for services provided by the physician, or, to others involved in my care.

Medicare patients:

I request that payment of authorized Medicare benefits be made on my behalf to Associates in Eyecare, P.C., for any services furnished me by those physicians. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

I request that payment of authorized "Medigap" benefits be made to Associates in Eyecare, P.C.. for any services furnished me by those physicians. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits or the benefits payable for related services.

I accept and understand the above payment/billing policies as outlined above.

Signed (Patient, or Guardian) _____ Date _____