

Patient Information Record

Patient Full Name _____ Date of Birth ___/___/___ Age ___

Preferred name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell # _____ Work # _____

Alternate Address (if applicable):

Address _____ City _____ State _____ Zip _____

Email Address _____ Preferred #: Home Cell Work

Social Security # _____ Gender: M F Marital Status: S M D W

Preferred Contact By: Phone Mail Email Is Texting OK? Yes No

Employer _____ Occupation _____

Financially Responsible Party If Different From Above: Name _____

Relationship _____ Address _____ Phone _____

Emergency Contact Person _____ Phone _____

Family Doctor / Primary Care Physician _____ Phone _____

How did you hear about us? family/friends website newspaper ads phonebook other: _____

Vision Insurance Information

Primary Insurance _____ ID# _____

Subscriber _____ Subscriber DOB _____

Secondary Insurance _____ ID# _____

Subscriber _____ Subscriber DOB _____

Financial Information

*I understand that the fees for all services rendered are due and payable on day of service unless other arrangements are made prior to the services being rendered.

*I understand that if services are not paid in full at the end of my care, I will be charged 1.5% interest on any balances over 30 days (18% annually).

*I understand that I will be responsible for any collections or attorney fees if such action is needed to collect payment.

*I request that payment of authorized insurance benefits be made either to me or on my behalf for any services furnished to me. I authorize any holder of medical or other information about me to be released to my insurance carrier needed to determine these benefits for related services.

Patient Signature _____ Date _____

Medicare Beneficiary Agreement

*Medicare will only pay for services that it determines to be reasonable and necessary under section 1862(a)(1) of the 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 is likely to deny payment for service(s).

*I have been notified by my physician that he or she believes that Medicare may deny payment for some services such as REFRACTION, DELUXE FRAME /LENSES. Medicare only pays for materials once after cataract surgery. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Patient Signature _____ Medicare # _____ Date _____