# Patient Information Record

Patient Legal Name_____Date of Birth____/____/____
Preferred name _____
Address_____City_____State____Zip_____
Home Phone_____ Cell #_____ Work #_____
Preferred #: □Home □Cell □Work
Preferred Contact By: □Phone □Mail □Email **Is Texting OK? □Yes □No**

Alternate Address (if applicable):
Address_____City_____State____Zip_____

Email Address_____

Social Security # _____

Gender: □M □F Marital Status: □S □M □D □W
Race/Ethnicity: □White □AA/Black □Hisp □Other_____

Employer_____Occupation_____

*Financially Responsible Party If Different From Above:* Name_____DOB_____
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:_____

## 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_____Date_____