New Patient Information

PERSONAL INFORMATION **(Please Print)**

Name_____ Date_____
Primary Care Physician_____
Date of Birth_____ Age_____ M / F Soc Security#_____
Address_____
Street City State Zip
Home Phone _____ Cell Phone _____
Email _____ Out of State Phone _____
Marital Status: Single Married Widowed Divorced
Employer _____ Work Phone_____
Address_____
Spouse Name_____ Employer_____

Who to notify in emergency (nearest relative or friend)?
Name_____ Relationship_____
Address_____
Street City State Zip
Home Phone_____ Work Phone _____

Complete if under 18 years or a student
Name of Father_____ Employer_____
Address _____ Phone_____
Name of Mother_____ Employer _____
Address_____
Street City State Zip

INSURANCE INFORMATION
Medicare #_____
Other Medical Insurance _____ ID#_____
Are you personally responsible for the payment of your fees? Yes No If not, who is?
Name_____ Relationship_____

FINANCIAL ASSIGNMENT AND AGREEMENT

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. You are responsible for knowing your benefits. We verify benefits and bill your supplement as a courtesy; however, if your supplement does not pay within 30 days of your primary insurance, we will bill you for the balance owed.**
2. **In Order To Control Your Cost of Billings, We Require That Your Charges For Office Visits Be Paid At The Conclusion Of Each Visit.**
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.
5. **A refraction, or eye glass exam, is a non-covered service by Medicare and most insurance plans. If you have a refraction and are given a prescription for new glasses, you will incur an out-of-pocket expense of $45, payable when services are rendered. Medicare beneficiaries who undergo cataract surgery are <u>only</u> covered for a portion of the cost of new glasses, <u>not</u> refractions.**

Signed **(Patient or parent if minor)**_____ Date_____