PATIENT INFORMATION

DEMOGRAPHIC INFO

NAME (LAST / FIRST / MIDDLE INITIAL)		DATE / /
STREET ADDRESS	APT. #	SOCIAL SECURITY # – –
		SPECIAL NEEDS ☐ WHEELCHAIR ☐ HEARING MPAIRED ☐ WALKER

STATE	ZIP CODE	BIRTH DATE	AGE	SEX ☐ MALE ☐ FEMALE

HOME PHONE	WORK PHONE	MARITAL STATUS ☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED

EMPLOYER NAME/ADDRESS	POSITION/DEPARTMENT
SPOUSE'S NAME	SPOUSE'S WORK PHONE ( )
EMERGENCY CONTACT – NAME AND PHONE NUMBER	YOUR E-MAIL ADDRESS

BILLING

GUARANTOR (FINANCIALLY RESPONSIBLE PERSON) NAME______________________ SOCIAL SECURITY # – –		RELATIONSHIP TO PATIENT ☐ SELF ☐ PARENT ☐ SPOUSE ☐ OTHER
STREET ADDRESS	BIRTH DATE	PHONE ( )
CITY	STATE	ZIP CODE

SEND WORKERS COMP BILL TO	AUTHORIZED BY NAME PHONE ( )

REFERRAL INFO

WHOM MAY WE THANK FOR TELLING YOU ABOUT OUR PRACTICE?	☐ FRIEND/FAMILY ☐ M.D. ☐ OPTOMETRIST ☐ SCREENING	☐ NEWSPAPER ☐ RADIO ☐ OTHER ☐ YELLOW PAGES

STREET ADDRESS	CITY	STATE	ZIP CODE

PRIMARY CARE DOCTOR	PHONE ( )

STREET ADDRESS	CITY	STATE	ZIP CODE

Agreement of Responsibility

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductibles and co-insurance may be collected at the time of service. I understand that I am financially responsible for charges not covered by my insurance company.

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her medical judgment.

Release of Information/Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me.

Medicare Authorization Medicare No. ________________________________

I request payment of authorized Medicare benefits be made on my behalf to SureVision Eye Centers – Midwest, LLC for any services furnished me by that physician/supplier. I authorize the holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Medigap Authorization Insurance Co.________________________________

Policy No.___________________________________

Fill out if you have a Medigap insurance policy for which you wish to assign benefits. A Medigap or Medicare Supplemental policy is a health insurance policy or other health benefit plan, offered by a private company, to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered by an employer to employees or former employees, as well as a policy or plan offered by a labor organization to members or former members.

This Agreement is in effect until revoked in writing by the patient.

Name: ____ Date: _______/________/________

Signature: ____