Cornea & Cataract
specialty center

----------Patient Information----------

Please fill out this form as completely as you can. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name_____ **Birthdate** ____/____/___
First **MI** **Last**

Gender: ___**Male** __**Female** **Age**_____ **Social Security #** _____-_____-_____

Address_____ **Apt.** ____**City**_____ **State** ____ **Zip** _____

Home Phone # _____ **Cell Phone #** _____ **Email** _____

__**Minor(under age 18)** ___**Married** ___**Divorced** ___**Widowed** ___**Single**___**Separated**

Employer _____ **Occupation** _____

----------Responsible Party----------

Who is the adult responsible for this account.

____**Self** ____**Other(fill in below)**

Name of Person Responsible _____
Relationship _____ **Phone #** _____

----------Referral----------

We would like to know who referred you to our office.

How did you hear about out office? ____ **Phonebook** ____**Sign** ____**Another Doctor**
____**Insurance Company** ____**Internet** ____ **TV/Commercial** ____ **Other**_____

Name of Primary Care Physician (PCP) _____

--------Insurance Information--------

Please give your insurance cards/information to the receptionist so that we can get proper benefits/authorization to provide services from your insurance.

1. **PrimaryInsurance**_____
   Member ID# _____ **Group#** _____

2. **Secondary Insurance**_____
   Member ID# _____ **Group#** _____

Signature on File, Assignment of Benefits, Financial Agreement and Notice of Privacy Practices

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to **CORNEA & CATARACT** for services furnished me by **CORNEA & CATARACT**. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand 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, my signature authorizes releasing the information to the insurer or agency shown. **CORNEA & CATARACT** accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

2. **MEDIGAP**: I understand that if a Medigap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to **CORNEA & CATARACT**, if possible or otherwise to me.

3. **OTHER INSURANCE**: I understand that **CORNEA & CATARACT** maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that **CORNEA** & CATARACT has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by **CORNEA & CATARACT** if I belong to a plan that does not appear on the above mentioned list.

4. **NON-COVERED SERVICES:** I understand that **CORNEA & CATARACT** maintains a list of health care service plans (i.e., HMOs PPOs) relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefits summary the care service plan furnishes to the patient: and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with **CORNEA & CATARACT** to obtain necessary health care service plan authorizations. The **REFRACTION** is the part of an eye exam to determine the prescription of corrective lenses. Without the refractions, we cannot provide a prescription for corrective lenses. Most insurance plans do not pay for this portion of an examination.

5. **FINANCIAL AGREEMENT:** As a courtesy, we are happy to assist you in filing your insurance claim. We will file one claim on your behalf. If your insurance company. Pays you directly or denies your claim, we ask that you pay the balance. We will allow a maximum of 90 days for the insurance payment to arrive. If we have not received payment within 90 days, we ask that you pay the balance. Our office policy calls for payment to arrive. I agree that in return for the services provided to the patients by **CORNEA & CATARACT,** I will pay my account at the time service rendered.

It is the patient's responsibility to be aware of the contract benefits of his/her insurance carrier or any co-payment or deductible obligation. If your insurance requires referrals for full benefits to be paid, it is your responsibility to verify that the referrals are in place prior to your visit. **If you do not have insurance,** payment in full is expected at the time of service unless financial arrangement has been made in advance with our billing department.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been provided with a copy of the Notice of Privacy Practices. I authorize the physician and staff **of CORNEA & CATARACT** to perform procedures necessary to assess and diagnose my condition properly and to perform treatments as may be prescribed by my attending physician during any and all visits to **CORNEA & CATARACT**. I understand that I am financially responsible for ALL charges for services rendered to me by **CORNEA & CATARACT**.

_____ _____

SIGNATURE DATE