Phone: (409)985-2569 PHYSCIANS EYE CENTER Fax: (409)985-2915

PATIENT INFORMATION

Must be same as on insurance card

Patient: _____ ☐Jr. ☐Sr. ☐III _____
Last First Middle Suffix Social Security Number

Address Mailing: _____
Street Apt. # City State Zip

Address Physical (IF DIFFERENT) _____

Home Ph#: _____
Work Ph#: _____
Cell Ph#: _____
Sex: ◯M ◯F DOB: _____
Employer: _____
Email: _____

☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED ☐SEPARATED
Marital Status
☐FULL ☐PART ☐NOT ☐SELF ☐MILITARY ☐RETIRED ☐FULL ☐PART TIME
Employment Status **Student Status**

Primary Care Physician (PCP) _____
Last First Phone # Fax#

(The American Recovery & Reinvestment Act requires your provider to offer your clinical information and active medication list via email which will be beneficial to your overall health.)

MEDICAL / VISION INSURANCE

Insurance: ☐Medicare ☐Medicare Replacement ☐Other _____

Insurance through employer: ☐YES ☐NO MEDICIAD: ☐YES ☐NO

Name of Employer: _____
Primary Medical Insurance: _____
Secondary Insurance: _____

VISION ONLY PLANS: ☐VSP ☐VBA ☐SPECTERA ☐OTHER _____
(Be advised it is the patient's responsibility to provide all insurance information and give notice to any changes including vision only plans)

RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

Name: _____ D.O.B.: _____
SSN#: _____
Mailing Address (only if different): _____
_____
Phone: _____ Cell Phone: _____
Relationship to Patient: _____

EMERGENCY CONTACT (Not living with you)

Name: _____
Phone: _____ Cell Phone: _____
Relationship to Patient: _____

NOTICE OF PRIVACY ACKNOWLEDGEMENT

I have reviewed this office's Notice of Privacy Practices, which explains how medical information will be used and disclosed. I understand that I am entitled to a copy of this document.
***List the names of any family members or friends that you give permission for us to release personal information to. This may consist of, but not limited to, information about appointments, medication, doctor visits, contact lenses and balances. _____

WRITTEN FINANCIAL POLICY

Be advised, co-payments, deductibles, and non-covered items are due at the time of service. Furthermore all applicable insurance must be provided at the time of service. For your convenience we accept cash, check, Visa, Master Card, American Express, Discover Card, and Care Credit Please speak with an account specialist for additional information.

Patient Signature: _____

ASSIGNMENT & RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage as indicated on this form and assign said insurance directly to PHYSICIANS EYE CENTER, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize PHYSICIANS EYE CENTER to release all information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____
RESPONSIBLE PARTY SIGNATURE ***DATE***

_____
RELATIONSHIP TO PATIENT (If applicable)

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to PHYSCIIANS EYE CENTER for any services furnished me by that practice. I authorize any holder of medical information about me to release to the Health Care Financing Administration, 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 or electronically submitted, my signature authorizes releasing of the information to the insurer or agency show. 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, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
RESPONSIBLE PARTY SIGNATURE ***DATE***

CONDITIONS OF WAIVER

I have been notified by my physicians office that in the event that any charges incurred to my account resulted in non-payment from my insurance company for any of the reasons listed below, I am personally, and fully responsible for any and all payment:

1. If physician is not a participant on your plan, services may not be covered
2. In the event a procedure is not a covered procedure by your insurance plan.
3. In the event a referral from your primary care physician is not received from your insurance plan.

I agree to comply with this waiver

_____ _____
RESPONSIBLE PARTY SIGNATURE ***DATE***