

PERSONAL INFORMATION

NAME _____
LAST FIRST MIDDLE INITIAL

ADDRESS _____
STREET OR POST OFFICE BOX CITY STATE ZIP CODE

TELEPHONE _____
HOME WORK - IF APPLICABLE MOBILE

SOCIAL SECURITY # _____ **BIRTHDATE** ____/____/____

GENDER Male Female **MARITAL STATUS** Single Married Widowed

EMPLOYER _____ Retired
COMPANY OCCUPATION

_____ Retired
SPOUSE'S COMPANY OCCUPATION

EYE DOCTOR _____
NAME CITY PHONE

MEDICAL DOCTOR _____
NAME CITY PHONE

EMERGENCY CONTACT _____
NAME (SOMEONE NOT IN YOUR HOUSEHOLD) PHONE

E-MAIL _____

HOW WERE YOU REFERRED TO US?

<input type="checkbox"/> Family Doctor	<input type="checkbox"/> Insurance Company	} _____ NAME
<input type="checkbox"/> Family Optometrist	<input type="checkbox"/> Phone Book	
<input type="checkbox"/> Friend/Relative	<input type="checkbox"/> Internet Listing	

INSURANCE INFORMATION

PRIMARY INSURANCE _____
INSURANCE COMPANY NAME ID NUMBER GROUP NUMBER

Prior Authorization Required

SECONDARY INSURANCE Yes No

(IF YES) _____
INSURANCE COMPANY NAME ID NUMBER GROUP NUMBER

Prior Authorization Required

WORKER'S COMP CLAIM? Yes No

_____ EMPLOYER ADDRESS

(IF YES) _____
CONTACT NAME CONTACT NUMBER PHONE

PERSON RESPONSIBLE FOR PAYMENT

_____ POLICY HOLDER'S NAME

_____ NAME RELATIONSHIP SOCIAL SECURITY #

_____ HOME PHONE WORK PHONE BIRTHDATE

IMPORTANT

Please complete every section that is applicable to you

MEDICARE

I hereby authorize by my signature that Eye Surgeons of Indiana and the Surgical Care Center (as applicable) submit a claim on my behalf for payment under the Medicare program. I also authorize by my signature that payment of Medicare program benefits be assigned and made payable on my behalf to Eye Surgeons of Indiana and / or the Surgical Care Center for all services and supplies provided to me by my doctor and the Surgical Care Center. I further authorize the release of my medical information to Medicare should Medicare require the information in order to adjudicate the amount due to Eye Surgeons of Indiana and / or the Surgical Care Center.

PATIENT NAME

MEDICARE #

SIGNATURE

DATE

OTHER INSURANCE

I hereby authorize by my signature that Eye Surgeons of Indiana and the Surgical Care Center (as applicable) submit a claim on my behalf for payment of benefits available through my insurance coverage with _____. I also hereby authorize by my signature that all payments due to me from my insurance carrier are herewith assigned and made payable on my behalf to Eye Surgeons of Indiana and / or the Surgical Care Center for all services and supplies provided to me by my doctor and the Surgical Care Center. I further authorize the release of my medical information to my insurance carrier should the information be required in order to adjudicate the claim submitted by Eye Surgeons of Indiana and / or Surgical Care Center.

PATIENT NAME

MEDICARE #

SIGNATURE

DATE

TO BE FILLED OUT BY ALL PATIENTS

I understand that Eye Surgeons of Indiana and / or the Surgical Care Center will submit a claim on my behalf to my insurance carrier. I agree to pay upon receipt of a bill, the full amount due and payable for the services and supplies I have received, less applicable insurance payments, unless prior payment arrangements have been made with the Collection Department. I understand that I will be responsible for all costs associated with the collection of my balance due, including collection fees and attorney's fees, should the balance become delinquent. I fully understand that I am financially responsible for the payment of the full amount of the services and supplies that I receive and I agree to pay the full amount or balance due thereof should my insurance carrier fail to make any payment, or make payment for less than the total of the charges. Insurance payments in question are a matter to be resolved between the insurance policyholder and his or her insurance carrier within 30 days of receipt of payment. I agree to pay the account balance in full, which is outstanding more than 30 days beyond the date of receipt of the insurance payment(s).

PATIENT NAME

DATE

SIGNATURE

DATE

WITNESS

DATE