THE MEDICAL EYE CENTER

PATIENT INFORMATION

Private and Confidential
Without Prejudice - Not for Publication

(Please Print)

Last Name _____ First Name _____ MI _____

Date of Birth (MM/DD/YY)_____ Age: _____

Address _____
Street City State Zip

Home Phone _____Work Phone _____Cell Phone_____

Best Phone Number to Use to Contact You? _____

Email address:_____

Occupation _____ Employer _____

Who to notify in emergency (nearest relative or friend)?
Name _____ Relationship _____
Home Phone _____ Work Phone _____

INSURANCE INFORMATION (Please give the insurance card to the receptionist)
Primary Insurance – Name of Insured: _____ DOB: _____
SSN: _____ Relationship to Patient: _____
Employer Name: _____
Secondary Insurance – Name of Insured: _____ DOB: _____
SSN: _____ Relationship to Patient: _____
Employer Name: _____

Complete if under 18 years or a student:
Name of Parent or Guardian Responsible for Payment:_____

NOTICE: A **refraction** is a measurement of the lens power necessary to prescribe glasses or other corrective lenses. **Most medical insurance plans**, **do not cover routine refractions or routine eye examinations**. There is a separate charge for that portion of the examination, since it is not a covered service. **THE MINIMUM CHARGE FOR A ROUTINE REFRACTION IS $35.00.**

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. **In order to control our cost of billing, it is your responsibility to pay any deductible amount, co-pay, or any other balance not paid for by your insurance at the beginning of each office visit.**
2. 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 released 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.
3. Requests for medical records require a minimum of one week to process, and a $10.00 processing fee.
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.

SIGNED ✕_____ Date _____
PERSON RESPONSIBLE FOR PAYMENT