Florida Eye & Laser Institute

PATIENT DEMOGRAPHICS

Name Last First MI				Date
Street Address				Social Security#
City	**Special Needs** ☐ WHEEL CHAIR ☐ WALKER ☐ HEARING IMPARED ☐ OTHER_____ ☐ TRANSLATOR LANGUAGE_____			
State	Zip Code	Birth Date	Age	Sex ☐ Male ☐ Female
Home Phone ( ) -	Work Phone ( ) -		Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Widowed	
(Out of State) Street Address		City	State	Zip Code
Home Phone ( ) -		Work Phone ( ) -		
Employer Name/ Address				Position Department
Spouse Name		Work Phone ( ) -		
Emergency Contact		Emergency Phone ( ) -		

BILLING

Guarantor (Financially Responsible Person)			Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other	
Address		Phone ( ) -		
Primary Ins.	Policy Holder	Policy ID #	SS#	Insured's DOB
Secondary Ins.	Policy Holder	Policy ID#	SS#	Insured's DOB
Send Worker's Compensation Bill To:	Authorized By		Date of Incident	

REFFERAL

Whom may we thank for telling you about our practice? NAME:				
☐ Friend/Family	☐ Optometrist	☐ Radio	☐ Sign	☐ Yellow Pages
☐ M.D.	☐ Patient	☐ News Paper	☐ Other	☐ Screening
Who is your Primary Care Doctor? NAME:				

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 time of service. I understand that I am financially responsible for charges not covered by my insurance company.

Accounts greater than 90 days past due are subject to an additional 35% service charge.

Consent to Treat

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

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 of 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 of authorized Medicare benefits to be made on behalf of Florida Eye & Laser Institute and its affiliates 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 payable to related services.

I understand that my signature request that payment be made and authorize release of medical information necessary to pay the claim. If "other insurance" is indicated in Item #9 of the HCFA 1500 form, or elsewhere on another approved claim form or electronically submitted claims, my signature authorizes the release of 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 deductables are based upon the charge determination of the Medicare carrier.

Medigap Authorization

Insurance Co: _____

Policy No: _____

Fill out if you have Medigap insurance policy for which you wish to assign benefit .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. By law, this excludes a policy or plan offered by an employer to employees or formerly employed, 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