

Mr/Mrs/Ms Name: _____ Date of Birth _____

Address: _____ Apt/Box#: _____

City: _____ State: _____ Zip: _____ E-mail: _____

Home Phone: () _____ Business Phone: () _____ Cell: () _____

Male Female Marital Status: Single Married Widowed Divorced Social Security #: _____

Name of Parent (if child): _____

Place of Employment): _____ Phone :() _____

(Patient's or Parent if Patient is a child)

Patient's Occupation: _____

Were you referred by a Physician: ___ Yes ___ No If Yes, by Whom: _____

NAME (Spouse or other Parent if child): _____

Address _____ Phone: () _____

(If different than patient such as Parent/Spouse living outside the home - include City/State/Zip)

Employer's Name & Address: _____

(Spouse or other Parent)

Work Phone Number: () _____

Insurance Company _____ Subscriber's Name: _____

Group #: _____ ID #: _____ Relationship to Patient: _____

Is this Worker's Comp ___ Yes ___ No If yes, Date of accident _____ Employer Notified: ___ Yes ___ No

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

- RELEASE OF INFORMATION:** I understand that Associated Ophthalmologists may disclose the PHI necessary for reimbursement of services rendered under Treatment, Payment or Operations to my insurance(s) or Worker's Compensation carrier.
- OTHER INSURANCE:** The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Associated Ophthalmologists, PC if I belong to a plan that is not on their list of contracts.
- NON-COVERED SERVICES:** I understand that Associated Ophthalmologists, PC contracts with health care service plans (i.e. HMO's, PPO's,) 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 benefit summary the health 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 Associated Ophthalmologists, PC to obtain necessary health care service plan authorizations.
- FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Associated Ophthalmologists, PC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Associated Ophthalmologists, PC for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Associated Ophthalmologists, PC. If co-payments and/or deductibles are designated by my insurance company or health plan I agree to pay them to Associated Ophthalmologists, PC. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

BENEFICIARY SIGNATURE OR AUTHORIZED PARTY

DATE

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Staff Initial _____