FAMILY EYE CARE OF N.E.PA

PATIENT NAME _____ BIRTHDATE _____ TITLE: MR. ☐
LAST FIRST M.I. MRS. ☐
MS. ☐
MISS ☐
DR. ☐
REV. ☐

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ EMAIL ADDRESS _____

PREFERRED CONTACT: HOME ☐ CELL ☐ WORK ☐ EMAIL ☐ SEX: MALE ☐ FEMALE ☐

PLACE OF EMPLOYMENT _____ OCCUPATION _____

STATUS: FULL TIME ☐ PART TIME ☐ UNEMPLOYED ☐ DISABLED ☐ STUDENT ☐ RETIRED ☐

MARITAL STATUS: SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐

ETHNICITY: HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐

RACE: NATIVE AMERICAN ☐
ALASKA NATIVE ☐
ASIAN ☐
AFRICAN AMERICAN ☐
PACIFIC ISLANDER ☐
WHITE ☐

PREFERRED LANGUAGE _____

SOCIAL SECURITY NUMBER _____

REFERRED BY _____

PERSON RESPONSIBLE FOR PAYMENT IF DIFFERENT FROM ABOVE

NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY _____ STATE _____

PHONE _____ SOCIAL SECURITY NUMBER _____ DOB _____

INSURANCE INFORMATION

INSURANCE NAME _____ INSURED'S NAME _____

INSURED'S EMPLOYER _____ INSURED'S BIRTHDATE _____

SOCIAL SECURITY NUMBER _____ MEDICARE NUMBER _____

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR INSURANCE AND/OR MEDICARE PAYMENT IS CORRECT. I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT OF MY INSURANCE AND/OR MEDICARE BENEFITS, AND I AUTHORIZE PAYMENT OF THESE BENEFITS DIRECTLY TO FAMILY EYE CARE OF NEPA ON MY BEHALF FOR ANY SERVICES AND MATERIALS FURNISHED. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND IT'S AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE TO RELATED SERVICES. IF I HAVE OTHER HEALTH INSURANCE COVERAGE (AS INDICATED ON ITEM 9 OF THE HCFA-1500 CLAIM FORM OR ELECTRONICALLY SUBMITTED CLAIM), MY SIGNATURE AUTHORIZES RELEASE OF THE ABOVE MEDICAL INFORMATION TO THE INSURER OR AGENCY SHOWN, AND AUTHORIZES MY DOCTOR TO ACT AS MY AGENT, AS ABOVE. FURTHER, IT IS THE PATIENT'S UNDERSTANDING THAT HE/SHE IS RESPONSIBLE FOR ALL FEES OF FAMILY EYE CARE OF NEPA NOT COVERED BY MEDICAL INSURANCE AND IN THE EVENT THAT A STATEMENT FOR FEES IS NOT PAID WITHIN THIRTY (30) DAYS OF THE DATE DUE, THE PATIENT SHALL BE FURTHER OBLIGATED TO PAY INTEREST ON ANY OUTSTANDING BALANCE AT THE RATE OF 18% PER ANNUM. REVISED FEBRUARY 19, 2003.

SIGNATURE _____ **DATE** _____

PARENT/GUARDIAN ☐ POA ☐ CAREGIVER ☐ PATIENT NOT MENTALLY/PHYSICALLY CAPABLE OF SIGNING ☐