

Patient Information Form

PRIMARY CARE PHYSICIAN _____

NAME (last, first MI) _____ (Mr., Miss, Mrs., Dr.)

Address _____

City, State

Zip _____

SSN _____ - _____ - _____ DOB _____ / _____ / _____ SEX:

M _____ F _____ Driver's License# _____ Phone

(Home) _____ Work _____

Employer/Occupation _____

Who Referred You? _____

ARE YOU UNDER THE CARE OF A SKILLED NURSING FACILITY?

IS THIS VISIT THE RESULT OF AN INJURY ON THE JOB?

PRIMARY INSURANCE CARD HOLDER

Subscriber's Name _____ SSN _____ - _____ - _____

Relationship to Patient _____

DOB _____ / _____ / _____

Insurance

Company _____

Secondary Insurance

Company _____

Copayment and deductible payments as determined by your agreement with your insurance carrier are due at the time of service. We will file your insurance claim, but not all insurance plans cover all services. In the event your insurance plan determines a service "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. Refraction fee is \$25.00.

Financial Responsibility Agreement-I hereby authorize this office to apply for benefits on my behalf for services rendered. I thoroughly understand that my insurance is an agreement between the insurance provider and myself, not between the insurance provider and this office. If authorization is required from my primary care physician, I have obtained such documentation prior to the visit. I therefore request payment from

my insurance company to be made to Eye Institute of Austin. I also understand that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any medical services rendered.

I certify that the information I have reported with regard to my insurance coverage is correct. I authorize the release of any necessary information, including medical records, to determine insurance benefits to which I may be entitled

I acknowledge the receipt of notice of privacy practices of EYE INSTITUTE OF AUSTIN.

Patient/Parent or Guardian Signature

Date