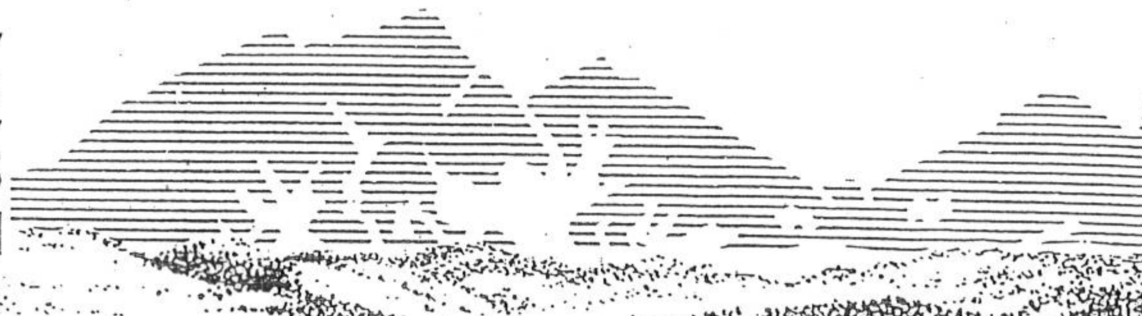
EYE CARE ASSOCIATES OF NEVADA



PATIENT'S NAME: ____________________ DATE: __________

WHAT NAME WOULD YOU LIKE TO BE ADDRESSED BY: ____________________

MARITAL STATUS: ____________________ MALE: ______ FEMALE: ______

SSN: ____________________ DATE OF BIRTH: __________

MAILING ADDR: ____________________

CITY: ____________________ STATE: ______ ZIP CODE: ______

PHYSICAL ADDR: ____________________

CITY: ____________________ STATE: ______ ZIP CODE: ______

HOME PHONE: ____________________ WORK PHONE: __________

EMAIL ADDRESS: ____________________ CELL PHONE: __________

HOW WOULD YOU LIKE TO BE CONTACTED: HOME WORK CELL TEXT EMAIL US MAIL

EMPLOYER: ____________________ OCCUPATION: __________

EMPLOYER ADDR: ____________________

CITY: ____________________ STATE: ______ ZIP CODE: ______

EMERGENCY CONTACT: SPOUSE, PARENT AND/OR RESPONSIBLE PARTY

NAME: ____________________ RELATIONSHIP: __________

D.O.B. __________ SSN: __________ HOME PHONE: __________

ADDR: (If different from above.) ____________________

CITY: ____________________ STATE: ______ ZIP CODE: ______

EMPLOYER: ____________________ WORK PHONE: __________

ADDR: ____________________ CELL PHONE: __________

FAMILY DOCTOR: ____________________ OPTOMETRIST: __________

REFERRED BY: ____________________ PHARMACY: __________

I understand I am responsible for payment of all services rendered.

SIGNATURE: ____________________ DATE: __________

RELEASE AND ASSIGNMENT

ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I understand I am financially responsible for the unpaid balance in the event that my medical insurance does not pay this account in full. I hereby assign and transfer any insurance benefits due me for services provided by Eye Care Associates of Nevada to be paid directly to them.

_______________________________ _______________________

SIGNATURE DATE

SIGNATURE ON FILE – MEDICARE

I request that payment of authorized Medicare benefits be made on my behalf to Eye Care Associates of Nevada for any services furnished me by Eye Care Associates of Nevada. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the issuer or agency shown.

Eye Care Associates of Nevada agrees to accept the charge determination of the Medicare carrier, Palmetto-GBA, as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_______________________________ _______________________

SIGNATURE DATE