PRAIRIE EYE CLINIC

Patient Information

First Name: _____ Street Address: _____

Middle Name: _____ _____

Last Name: _____ City: _____

State: _____ Zip: _____

Gender: O Male O Female Primary Phone: (____) _____

Date Of Birth (MM/DD/YYYY) ____/____/____ Other Phone: (____) _____

Responsible Party Name: _____

Relationship: O Spouse O Parent O Other _____

Email Address: _____

Use for: O Exam Reminder O Order Notification O Appointment Reminder

Text Phone #: (____) _____ Cell Service: _____ (Verizon, Sprint, AT&T, etc)

Use for: O Exam Reminder O Order Notification O Appointment Reminder

O I don't wish to use e-mail or text for reminders.

EMAIL AND TEXT INFORMATION IS PRIVATE AND TO BE USED ONLY AS DIRECTED ABOVE

Privacy Notice Acknowledgment

By initialing below, I acknowledge that I have reviewed and was offered a copy of the privacy policy of this organization.

Initials: _____

O I do not have insurance coverage. (Skip to signature at the bottom of the form)

Primary Insurance

Insurer Name: _____

Subscriber Name: _____

Secondary Insurance

Insurer Name: _____

Subscriber Name: _____

Release of Information Authorization

By initialing below, I am authorizing this office to release any information necessary to process claims on my behalf.

Initials: _____

Assignment of Benefits Authorization

By initialing below, I am authorizing payment of medical benefits to the provider of those services/materials furnished to me.

Initials: _____

Acknowledgment of financial responsibility

Our office will assist you with pre-determination of benefits and estimated expenses for treatment. We will also furnish sufficient documentation to assist you in obtaining the benefits to which you are entitled. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the provider and is not a substitute for payment. The estimated amount not covered by your insurance is due at the time of service. Our estimates are subject to final approval by your insurance company; therefore, the amount due our office is subject to change as well.

By signing below, I acknowledge that any amount due after insurance has paid or denied is my responsibility.

Signature: _____ Date: _____