WELCOME TO OUR OFFICE

Name____Date____/____/____
First Middle Initial Last Suffix

Address____City_______________ State_______ Zip_________

Date of Birth: ______/______/______ Soc.Sec.#____________________ Sex □ M □ F

Phone: Home #________________ Cell#_______________Email__________________________________

Employer____________________________ Occupation____________________Work#__________________

How did you hear about our office? □ Internet □ Yellowpages □ Friend/Family □ Other ____________________

Responsible Party (if different than above)

Person responsible for account______________________________ Soc.Sec.#________________________

Relation to patient____________________DOB___/___/_____ Preferred Phone________________________

Address (if different from above)_________________________City____________State_______Zip _______

Medical/ Vision Insurance Information

Many eye problems are covered by your medical insurance

Major Medical Plan_________________________

ID #____________________________________

Group #_________________________________

Subscriber's Name__________________________

Subscriber's SS# ___________________________

Vision Plan_________________________________

ID #____________________________________

Group #_________________________________

Subscriber's Name__________________________

Subscriber's SS# ___________________________

<u>All copays and individual portions of your balance are due at time of service.</u> If you participate in any insurance plans, you are responsible for these amounts at the time of service. Eyes on Camp Bowie, P.A. will bill your insurance directly for their portion. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize Eyes on Camp Bowie, P.A. to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

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Patient Signature, Insured/Guardian **Date**

<u>Medicare Authorization</u>

I request that payment of authorized Medicare benefits be made either to me or on my behalf, to Eyes on Camp Bowie, P.A.. for any services furnished to me. I authorize any holder of medical information about me to release to the HCFA and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made authorizes releasing of the information necessary to pay the 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 authorized releasing of the information to the insurer agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge , and the patient is responsible only for the deductible,co-insurance,and non covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

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Beneficiary Signature, Insured/Guardian **Date**

Dilation Information

Many times it is necessary to dilate your eyes to better assess certain eye and health conditions. We will recommend dilating your eyes if you or anyone in your family has cataracts, glaucoma, diabetes, or hypertension, or if you are experiencing flashing lights, floaters, or are highly nearsighted. The doctor may also recommend dilation for certain other medical conditions. The effect of dilation usually lasts from 2-6 hours and involves light sensitivity. We suggest you have someone drive you home as your distance vision may be blurry. By signing below, I acknowledge that I have been advised that dilation is an essential part of a vision and eye health examination. I understand that if not dilated, my doctor might miss seeing inside my eyes for signs of serious health problems such as but not limited to diabetes, hypertension, glaucoma, cataracts, and possibly even cancer. I hold Dr. Zimmerman and her agents harmless for any circumstances which might later occur as a result of a condition not detected.

SIGN ONLY IF DECLINING DILATION: Signature: ____

Date