Personal Information

Date

Patient's Name First Middle Last Age

Spouse's Name First Middle Last

Street Address

City State Zip

Sex ❒ M ❒F

MRN:

Patient's Birthdate ____ ____ / ____ ____ / ____ ____

Patient's Social Security Number. Last 4 Digits ____ ____ ____ ____

Telephone Numbers

Home / Cell (____) _____ Home / Cell (____) _____

Work (____) _____ Email Address _____

WHO TO CONTACT IN CASE OF EMERGENCY

Name _____ Phone Number (____) _____

Pharmacy Information

Mail Order Pharmacy (if applicable) _____

Local Pharmacy _____

Location _____

Phone Number _____ Zip Code _____

NOTICE OF PRIVACY PRACTICES RECEIVED

X _____ **Date** _____

For Office Use:

About the financial arrangements and your medical and vision insurance . . .

We are committed to providing excellent eye health care for you and your family. We also work to assure that you will receive your maximum allowable benefit. However, your assistance is necessary to achieve these goals and you must remember the following:

1. Your insurance coverage is a contract between you and/or your employer and the insurance company. We are not a party to that contract.

2. Our fees are *usual, customary, and reasonable* and they are frequently covered up to the maximum allowable reimbursement for the type of service you will receive. This applies only to insurance companies who pay on the baes of "U.C.R." (usual, customary, and reasonable), reimburse based on an arbitrary schedule of fees, bearing no relationship to the current standard of cost of care in this area.

3. As your eye care provider our relationship is with you, not your insurance company. Your insurance carrier – not our office – determines the reimbursement to which you are entitled.

4. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We try to let you know in advance about services not covered if we have that knowledge.

Payment is expected on the date of service unless prior arrangements are made.

We accept cash, check, MasterCard, VISA, American Express or Discover cards. All insurance claim forms that have been properly completed and submitted at the time of your visit are processed promptly as a courtesy to our patients. We accept the assignment of many insurance benefits and will indicate if this applies to you at your visit.

If you have any questions or are uncertain about your insurance coverage, please do not hesitate to ask us. We are here to help you.

Insurance Release of Information and Assignment of Benefits

I hereby assign my insurance benefits to be paid directly to the following: James W. Klein, M.D., Mariann M. Channell, M.D., Daniel S. Malach, M.D., or Mark E. Bernthal, O.D. I understand that I will be responsible for the non-covered benefits. I authorize the above doctor(s) to release any information acquired in the course of my examination or treatment which may be necessary to process any insurance claim.

_____ _____

Date *Patient Signature or authorized representative*