# Florida Eye & Laser Institute

## PATIENT DEMOGRAPHICS

| | | | | |
|---|---|---|---|---|
| Name<br>Last First MI | | | | Date |
| Street Address | | | Social Security# | |
| City | **Special Needs** ❑ WHEEL CHAIR ❑ WALKER ❑ HEARING IMPARED<br>❑ OTHER_____ ❑ TRANSLATOR LANGUAGE_____ | | | |
| State | Zip Code | Birth Date | Age | Sex<br>❑ Male ❑ Female |
| Home Phone<br>( ) - | Work Phone<br>( ) - | Marital Status<br>❑ Married ❑ Divorced<br>❑ Single ❑ Widowed | | |
| **(Out Of State)** Street Address | | City | State | Zip Code |
| Home Phone<br>( ) - | Work Phone<br>( ) - | | | |
| Employer Name / Address | | Position Department | | |
| Spouse Name | Work Phone<br>( ) - | | | |
| Emergency Contact | Emergency Phone<br>( ) - | | | |

## BILLING

| | | | | |
|---|---|---|---|---|
| Guarantor (Financially Responsible Person) | Relationship to Patient<br>❑ Self ❑ Spouse ❑ Parent ❑ Other | | | |
| Address | Phone<br>( ) - | | | |
| Primary Ins. | Policy Holder | Policy ID# | SS# | Insured's DOB |
| Secondary Ins. | Policy Holder | Policy ID# | SS# | Insured's DOB |
| Send Worker's Compensation Bill To: | Authorized By | Date of Incident | | |

## REFERRAL

| | | | | |
|---|---|---|---|---|
| Whom may we thank for telling you about our practice? NAME: | | | | |
| ❑ Friend / Family | ❑ Optometrist | ❑ Radio | ❑ Sign | ❑ Yellow Pages |
| ❑ M.D. | ❑ Patient | ❑ News Paper | ❑ Other | ❑ Screening |
| Who is your Primary Care Doctor? NAME: | | | | |

## Agreement of Responsibility

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductibles and co-insurance may be collected at the time of service. I understand that I am financially responsible for charges not covered by my insurance company. Failure to pay all outstanding balances on time will result in accural of Collection Fees of 35% of the outstanding balance

## Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her medical judgement.

## Release of Information/Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me.

**Medicare Authorization** **Medicare No:**_____

I request payment of authorized Medicare benefits be made on my behalf to Florida Eye & laser Institute and its Affiliates for any service is furnished me by that physician/ supplier. I authorize the holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits payable to related services.

I understand that my signature request that payment be made and authorize release of medical information necessary to pay the claim. If "other insurance" is indicated in Item #9 of the HCFA1500 form, or elsewhere on other approved claim form or electronically submitted claims, my signature authorizes the release of information to the insurer or 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 the uncovered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

**Medigap Authorization** **Insurance Co:**_____

**Policy No:**_____

Fill out if you have a Medigap insurance policy for which you wish to assign benefits. A Medigap or Medicare Supplemental policy is a health insurance policy or other health benefit plan, offered by a private company, to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered by an employer or employees or formerly employed, as well as a policy or plan offered by a labor organization to members or former members.

This Agreement is in effect until revoked in writing by the patient.

_____ _____

Name Date

_____

Signature