

MILAUSKAS EYE INSTITUTE
GENERAL PATIENT INFORMATION

DATE _____

PATIENT: MR / MRS / MS/ MISS DATE OF BIRTH _____ AGE ____ MALE ____ FEMALE ____

LAST NAME FIRST NAME M.I.

MAILING ADDRESS CITY STATE ZIP

ALTERNATE ADDRESS CITY STATE ZIP

(____) _____ (____) _____
HOME PHONE WORK PHONE SOCIAL SECURITY NUMBER

EMPLOYER EMPLOYER ADDRESS

PARENT/GUARDIAN – IF UNDER 18: MR MRS MS MISS DATE OF BIRTH _____ MALE / FEMALE

LAST NAME FIRST NAME M.I.

EMPLOYER EMPLOYER ADDRESS

(____) _____
WORK PHONE SOCIAL SECURITY NUMBER RELATIONSHIP TO PATIENT

PERSON TO CONTACT IN EMERGENCY (____) _____ (____) _____
HOME PHONE WORK PHONE

PRIMARY INSURANCE _____

INSURED NAME _____ ID # / MEMBER # _____

INSURED DATE OF BIRTH _____ GROUP # / PLAN # _____

INSURED EMPLOYER _____ PTS RELATION TO INSURED: SELF / SPOUSE/ CHILD

SECONDARY INSURANCE _____

INSURED NAME _____ ID # / MEMBER # _____

INSURED DATE OF BIRTH _____ GROUP # / PLAN # _____

INSURED EMPLOYER _____ PTS RELATION TO INSURED: SELF / SPOUSE/ CHILD

VISION INSURANCE _____

INSURED NAME _____ ID # / MEMBER # _____

INSURED DATE OF BIRTH _____ GROUP # / PLAN # _____

INSURED EMPLOYER _____ PTS RELATION TO INSURED: SELF / SPOUSE/ CHILD

GENERAL INFORMATION:

It is the patient's responsibility to give our office the correct patient & insurance information. This includes mailing address & any change of insurance carriers. This is very important due to filing limitations. If claim(s) are not paid due to incorrect information received, the patient will be responsible for any balance.

PATIENT / GUARDIAN / INSURED'S SIGNATURE

DATE

(CONTINUED)

ALL PATIENTS

All patients without any medical insurance coverage or those who choose not to use their insurance coverage will be expected to pay the full charge at time of service.

REFRACTIONS (EXAM FOR GLASSES)

All patients that are new to Milauskas Eye Institute or that have not been seen in over one year will have a refraction as a part of their comprehensive exam unless they are being seen for an urgent care need. Refractions are not a covered service for Medicare or most other insurance plans, therefore the patient will be responsible for paying the refraction fee. This payment is due at time of service.

PATIENT / GUARDIAN / INSURED'S SIGNATURE

MEDICARE PATIENTS

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

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay for the claim. If item 9 of the HCFA-1500 form is completed, my signature authorizes releasing of the 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 only responsible for the deductible, coinsurance, and non-covered charges. Coinsurances and the deductible are based upon the charge determination of the Medicare carrier.

BENEFICIARY SIGNATURE

HMO & COMMERCIAL PATIENTS

I hereby authorize and request my insurance company to pay directly to Milauskas Eye Institute the amount(s) due on my claim for services rendered to my dependant(s) or to me. I further agree, should the amount be insufficient to cover the entire medical and surgical expense, I will be responsible for the difference, and if the nature of the services were such that they are not covered by the policy, I will be responsible to Milauskas Eye Institute for payment of the entire bill.

If I do not get the proper authorization to be seen at Milauskas Eye Institute, I will be responsible for all charges incurred.

Please read you insurance information so that all of the plan requirements are clear to you. Questions should be referred to your health plan.

INSURED'S SIGNATURE