

SERVICES PROVIDED ON A NON-DISCRIMINATORY BASIS

PLEASE PRINT

Date _____

Referred by _____

Patient name _____ Home phone no _____

First Middle Last

Date of birth _____ Age _____ Social Security no _____

Home address _____

City _____ State _____ Zip _____

County _____ Sex Male Female

Patient's occupation _____ Employer Name, address & phone number _____

Circle race (optional): Caucasian Hispanic African American Asian Other

Circle marital status: Married Separated Divorced Widowed Child Single

Name and telephone number of a friend/relative not living with you who knows how to reach you in case of an emergency _____

Primary health insurance information	Secondary health insurance information
Insurance company	Insurance company
Policy holder	Policy holder
Relationship to patient	Relationship to patient
Date of birth	Date of birth
Social security #	Social security #
Employer	Employer
Employer address	Employer address
Employer phone #	Employer phone #
Occupation	Occupation
Person responsible for bill name, address & phone number:	

IF THE PATIENT IS A MINOR, PLEASE FILL OUT THE INFORMATION BELOW

Father, Mother, or legal guardian's name and phone number _____

Address _____

Employer name and phone number _____

Employer address _____

Occupation _____ Date of birth _____ Social security no _____

Worker's compensation: If you were sent here after being injured at work who is the responsible employer?

_____ Name and Phone # of person authorizing visit _____

PLEASE SIGN BELOW AFTER YOU HAVE READ ALL OF THE FOLLOWING PARAGRAPHS WHICH APPLY TO YOU

Patient Signature (You must be 18 years old to sign this form. If you are not, please tell our receptionist.)

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form.

Relationship to patient

Source of Authority

The following paragraphs apply to all patients

Acknowledgement of Receipt of Notice of Privacy Practices

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The **Notice of Privacy Practices** describes these uses and disclosures in detail.

Please check the appropriate box

I acknowledge that I have received the Notice of privacy practices from Missouri Eye Institute

I decline a copy of the Notice of Privacy Practice

Consent

I consent to examination, diagnostic studies, and treatment as deemed appropriate by Doctors of Missouri Eye Institute and also to the release of information concerning that care for insurance purposes or for further medical care when necessary.

This paragraph applies only to Medicare patients

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

I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from this provider.

This paragraph applies only to self- pay and private health insurance patients

I request that payment of authorized benefits be made on my behalf to Missouri Eye Institute for any services furnished to me by that provider. I authorize any holder of medical information about me to be released if needed to determine these benefits or the benefits payable for related services.

Financial Agreement

All co-pays and co-insurance are due at the time of service. If you have no insurance you need to pay the balance in full, unless prior arrangements have been made. We will file your insurance as a courtesy to you. If your insurance fails to pay, you will be responsible for the bill.
