Welcome To Our Office

PATIENT INFORMATION

LAST NAME FIRST MIDDLE *(PLEASE PRINT)*	S.S. #	MARITAL STATUS S M W D SEP	SEX M F	BIRTH DATE / /	AGE
STREET ADDRESS/MAILING ADDRESS	CITY AND STATE, ZIP	CELL PHONE#		HOME PHONE #	
PATIENT'S OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED		BUS. PHONE #	EXT. #
EMPLOYER'S STREET ADDRESS	CITY AND STATE			ZIP CODE	
SPOUSE OR PARENT'S NAME OR EMERGENCY CONTACT	SPOUSE'S S.S. #	SPOUSE'S BIRTH DATE			
SPOUSE OR PARENT'S STREET ADDRESS	CITY AND STATE	ZIP CODE		HOME PHONE #	
SPOUSE OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED		BUS. PHONE #	EXT. #
EMPLOYER'S STREET ADDRESS	CITY AND STATE			ZIP CODE	

How did you hear about our office? (Please Check) **Yellow Pages** ____ **Friend** ____ **Brochure/Mail** ____ **Other** ____

Name of Physician referring you. _____

Address of Physician referring you. _____

In keeping with HIPPA regulations, we must have the following authorizations on file

PLEASE CIRCLE

They **may** / **may not** leave a message at my home number.

They **may** / **may not** call me at work and / or leave a message.

They **may** / **may not** release information and / or test results to my physicians.

They **may** / **may not** leave test results on my answering machine.

They **may** give results to / and or discuss my health care / insurance / billing with:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

This authorization will remain in effect until I provide written instructions otherwise.

A copy of our privacy notice of practice is posted in our waiting area but if you would like an individual copy of this it is available at our front desk.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare/Other Insurance company benefits be made either to me or on my behalf to **Morisstown Regional Eye Center** for any services furnished me by that physician/supplier. 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 to related services.

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE BOOKKEEPER.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCRA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare/Other Insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare/Other Insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/Other Insurance company.

Signature_____ Date_____

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