

(Please use BLACK ink only)

PATIENT INFORMATION SHEET

Mr/Mrs/Ms/Dr _____
Last Name First Middle Initial

Address _____
Street City State Zip

Home Phone (____) _____ Birthday _____ Age _____ SS# _____
Month - Day - Year

Cell Phone (____) _____ E-mail Address _____

Responsible party (if other than above) _____ Ph (____) _____ Birthdate _____ SS# _____
Month - Day - Year

How did you learn about our practice? _____ Medical Doctor/City _____

Allergies to any medications _____

Patient's Employer _____ Full-time Part-time Not Employed Self Employed Retired

Patient's Occupation _____ Business Address _____ Business Phone (____) _____

Patient's Marital Status (circle) S / M / Div. / Wid. / Partner *Name of spouse/partner _____

Spouse/Partner's Employer _____ Business Phone (____) _____

Spouse/Partner's Business Address _____

Patient's payment information for first visit: Check Cash Credit Card Insurance

Primary Insurance/Mailing Address _____

Name of Insured (Subscriber) _____ Member ID# _____ Group # _____

SS# _____ Birthdate _____ Relationship to Insured: Self Spouse Child Other _____
Month - Day - Year

Secondary Insurance/Mailing Address _____

Name of Insured (Subscriber) _____ Member ID# _____ Group # _____

SS# _____ Birthdate _____ Relationship to Insured: Self Spouse Child Other _____
Month - Day - Year

Please list an **EMERGENCY CONTACT**, preferably not living with patient (other than responsible party):

Contact name _____ Relationship to pat.: Spouse Child Parent Friend Neighbor Other

Address _____ Phone (____) _____

Our goal is to provide you with the best medical care available. In order to achieve our goal and minimizing escalating administrative costs, we ask for your understanding and cooperation regarding the following payment/insurance policies:

1. We ask that payments be made at the time of your visit unless other arrangements have been made in advance.
2. If you are a member of an HMO or POS plan, you need to have a VALID referral for each office visit and surgical procedure. Please call our office in advance to make sure you have the necessary forms and authorization.
3. It is our policy to render periodic statements for services on a monthly basis. In the event our statements for services are not paid within sixty (60) days after you received an invoice, we reserve the right, at our option, to charge interest on the balance due, at a rate of one-and-one-half (1½) percent each month.
4. Our payment policy also requires that payments for Refraction are expected at the time of service for all Medicare patients as well as for those patients whose insurance does not cover Refraction.

Non-Medicare patients:

I hereby authorize payment directly to Chicago Cornea Consultants, Ltd. of the surgical and/or medical benefits, if any, otherwise payable to me for services as rendered. I authorize the physician to release such medical or other information regarding this treatment or subsequent treatment relative to this injury or illness for the purpose of obtaining reimbursement on my behalf for services provided by the physician, or, to others involved in my care.

Medicare patients:

I request that payment of authorized Medicare benefits be made on my behalf to Chicago Cornea Consultants, Ltd. for any services furnished me by those physicians. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

I request that payment of authorized "Medigap" benefits be made to Chicago Cornea Consultants, Ltd. for any service furnished me by those physicians. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits or the benefits payable for related services.

I accept and understand the payment/billing policies as outlined above.

Signed (Patient or Guardian) _____ Date _____