

Patient Information

Name _____ Date _____
 Home Address _____ City/State/Zip _____
 (H)Phone: (____) _____ Gender: M / F SS# _____ / _____ / _____
 (C)Phone: (____) _____ Email Address: _____
 Birth Date ____ / ____ / ____ Marital Status: Married/Single/Other _____
 Employer _____ Occupation _____
 Work Address _____ Work # _____
 Spouse's name (parent's name if a minor) _____
 Whom may we thank for referring you? _____
 How did you hear about us? _____
 Person to contact in case of emergency _____

RESPONSIBLE PARTY

Person responsible for account _____
 Relationship to patient _____ Phone: _____
 Address (if different from above) _____

INSURANCE INFORMATION

Name of insured _____ Relationship to patient _____
 Birthdate _____ Social Security # ____ / ____ / ____
 Name of employer _____ Work# _____

All insurance plans must be approved prior to service. Payment for professional fees, including co-payments, is due on the date of service. All orders for glasses or contacts require at least 50% deposit before ordering and the balance must be paid before materials will be dispensed. Any account sent to collections will be assessed a 50% collection fee.

Insurance Authorization:

I understand that by signing this form I authorize Marrow Family Eyecare, PC to release to my insurance company and its agents, upon their request, any information needed to determine benefits payments or to be used for quality assessments or provider reviews for this or a related claim. Additionally, I permit a copy of this authorization to be used in place of the original, and furthermore request payment of insurance benefits to be paid to Marrow Family EyeCare, PC on my behalf. I understand that I am responsible for any costs in excess of the benefits payable by my insurance plan or if the claim is denied. I understand the fee policies for this office as described above.

Medicare Recipients:

I request that payment of authorized Medicare benefits be made on my behalf to Marrow Family EyeCare, PC, for services furnished me by Marrow Family EyeCare, PC. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of the medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the CMS 1500 form or elsewhere on the approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Marrow Family EyeCare, PC accepts the charge determination of the Medicare carrier as the full charge, and I'm responsible only for the deductible, co-insurance and noncovered services. Co-insurance and deductible are based upon the charge determination of the Medicare Carrier.

Signature: _____ Date: _____