# Lake Lazer Eye Center

SPECIALIZING IN DISEASES & SURGERY OF THE EYE

## PATIENT INFORMATION

Last Name_____ First Name_____ M.I._____

DOB_____ SSN_____ Gender_____ Marital Status: M S W D

Race: African American/Black American Indian/Alaskan Native Caucasian/White Native Hawaiian/Pacific Islander Other Decline to Answer

Ethnicity: Hispanic/Latino Non Hispanic/Latino Decline to Answer

Home Address_____ City_____ State____ Zip Code_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email Address_____

Employment Status: Active Duty Military Full-Time Part-Time Retired Self-Employed Student Full-Time Student Part-Time Unemployed

Employer_____ Employer Phone_____

Family Physician_____ Physician Phone_____

How did you hear about us?/Referred by_____

Emergency Contact_____ Phone_____

## CURRENT MEDICATIONS (include regularly used OTC medications)

_____

_____

## PRIMARY INSURANCE - Please provide insurance card(s) with this completed form

Policy Holder's Name_____ Policy Holder's DOB_____

Address_____ City_____ State_____ Zip Code_____

Insurance Company_____ Insured's ID#_____

Policy Group ID#_____ SSN_____

Policy Holder's Relationship to Patient_____ Do you have Medicare Coverage?_____

## SECONDARY INSURANCE

Policy Holder's Name_____ Policy Holder's DOB_____

Address_____ City_____ State_____ Zip Code_____

Insurance Company_____ Insured's ID#_____

Policy Group ID#_____ SSN_____

Policy Holder's Relationship to Patient_____ Do you have Medicare Coverage?_____

**Financial Agreement:**

We participate in many different insurance plans. We will file your insurance claims for the companies with whom we are contracted. You will be responsible for any co-payments and/or deductibles at the time services are rendered. For some insurance we accept assignment of benefits but in all cases we require that the guarantor, the person who is financially responsible, is personally liable for all balances not covered by insurance. It is our responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance companies. You will be responsible for co-payment, deductibles, out-of-network amounts or any portion your insurance company indicates is your responsibility. Payment for co-pays and/or deductibles are expected at the time of service. If this fee is not covered by insurance it will be your responsibility.

**Assignment of Insurance Benefits:**

I hereby authorize direct payment to Lake Lazer Eye Center of any insurance or health benefits otherwise payable to or on behalf of the patient for examination, treatment and/or devices at the rate not to exceed Lake Lazer Eye Center's usual charges. I understand that verification of insurance coverage obtained over the phone or online is estimated and does not guarantee payment and that insurance coverage is a relationship between the patient and his/her insurance company(s). I agree to accept financial responsibility for any charges for goods and services rendered to the patient that are not paid by insurance or health benefit plan pursuant to this assignment of benefits.

**Release of Information:**

I hereby authorize Lake Lazer Eye Center to release any medical information about the patient necessary to determine liability for payment and to process any claim for examination, treatment and/or devices received by the patient. I also authorize Lake Lazer Eye Center to release the medical records or the patient to the patient's referring physician or family physician indicated on this form.

**Financial Responsibility Agreement by Other than Patient's Legal Representative:**

I agree to accept financial responsibility for the goods and services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Benefits, and Release of Information provisions above.

**HIPAA Acknowledgement:**

By signing below, I acknowledge that I received a copy of Lake Lazer Eye Center's Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted on the website and that any revised Notice of Privacy Practices will be made available.

**I HAVE READ AND AGREE TO THE TERMS ABOVE:**

_____

Patient or Legal Representative (print)

| | |
|---|---|
| Patient or Legal Representative (signature) | Date |