

PATIENT FINANCIAL INFORMATION SHEET

DATE _____ REFERRED BY _____

PATIENT'S FULL NAME _____ HM PH: (____) _____

ADDRESS _____
street city state zip

EMAIL ADDRESS: _____ CELL # _____

SEX _____ BIRTHDATE _____ AGE _____ SS# _____
MM/DD/YYYY

PATIENT'S EMPLOYER _____ WK PH: _____

PERSON RESPONSIBLE FOR BILL

NAME _____ HM PH: (____) _____

ADDRESS _____
street city state zip

EMPLOYER _____ WK PH: _____

SOCIAL SECURITY NUMBER: _____ RELATIONSHIP TO PATIENT _____

PRIMARY MEDICAL INSURANCE COVERAGE: _____

POLICYHOLDER NAME: _____ DATE OF BIRTH: _____

SS#: _____ POLICY #: _____ GROUP#: _____

SECONDARY MEDICAL INSURANCE COVERAGE: _____

POLICYHOLDER NAME: _____ DATE OF BIRTH: _____

SS#: _____ POLICY #: _____ GROUP#: _____

DO YOU HAVE A SEPARATE VISION POLICY THAT COVERS YOUR ROUTINE EYE CARE? Y or N

VISION INSURANCE COVERAGE: _____

POLICYHOLDER NAME: _____ DATE OF BIRTH: _____

SS#: _____ POLICY #: _____ GROUP#: _____

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING. THIS INFORMATION IS REQUIRED FOR BILLING AND DEBT COLLECTION PURPOSES.

FATHER'S NAME _____ FATHER'S DATE OF BIRTH: _____

FATHER'S SOCIAL SECURITY NUMBER: _____

MOTHER'S NAME _____ MOTHER'S DATE OF BIRTH: _____

MOTHER'S SOCIAL SECURITY NUMBER: _____

By signing below, I agree that:

- 1) I have received or reviewed a copy of the Notice of Privacy Practices for The Raleigh Eye Center, P.A.
- 2) I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare or Commercial insurance by phone, mail, or FAX. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply. This authorization is in effect until I choose to revoke it.

X _____ DATE _____
Patient or Legal Guardian

