DATE: _____/_____/_____

PLEASE FILL IN THE FOLLOWING WHERE APPLICABLE:

NAME____DOB:_____/_____/_____
AGE: _______SEX: M F

ADDRESS____

CITY______________________________STATE_________ZIP____________SS#________________________

PHONE HOME:________________________WORK:___________________LAST EYE EXAM _______________

CELL PHONE: _________________ EMAIL: ____

Spouse, Parent or Guardian, if applicable____

Your Employer____ Self Employed __________Student ________

How would you like to be contacted? Email Home Phone Cell Phone MAIL

With whom are we allowed to discuss your health information?

Spouse______________________________ Other____
Name Name/relationship

Please let us know whom to thank for your referral to our office? ____

Signature on File, Assignment of Benefits, Financial Agreement

1. **FINANCIAL AGREEMENT/OTHER INSURANCE:** I agree that in return for the services provided to the patient by Midwest Eye Consultants, P.C., I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Midwest Eye Consultants, P.C. for payment. I understand that payment for lenses is due at the time of order and the payment is non-refundable. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Midwest Eye Consultants, P.C. if I belong to a plan that is not contracted. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate and any collections and/or legal fees up to 50% are also my responsibility. Any type of benefits under a policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Midwest Eye Consultants, P.C. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Midwest Eye Consultants, P.C. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.*

2. **RELEASE OF INFORMATION:** Midwest Eye Consultants, P.C. may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Midwest Eye Consultants, P.C. for reimbursement for services rendered, and (2) any health care provider for continued patient care. Midwest Eye Consultants, P.C. may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

3. **MEDICARE/MEDIGAP:** I request that payment of authorized Medicare benefits be made on my behalf to Midwest Eye Consultants, P.C., for services furnished me by Midwest Eye Consultants, P.C. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) 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 medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Midwest Eye Consultants, P.C. accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier. Medicare #______________________________

4. **NON-COVERED SERVICES:** I understand that Midwest Eye Consultants, P.C. contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Midwest Eye Consultants, P.C. to obtain necessary health care service plan authorizations.

____ ___________
Beneficiary Signature or Authorized Party Date