



**PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST**

**NAME:** First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_ SEX: M F

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ AGE: \_\_\_\_ SSN: \_\_\_\_\_ Drivers Lic. # \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Divorced Student: Y N Handicapped: Y N

MAILING ADDRESS: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Nearest Relative NOT living with you: Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Responsible Party: Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

PRIMARY PHYSICIAN: \_\_\_\_\_ REFERRING PHYSICIAN: \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_ **Secondary Insurance:** \_\_\_\_\_

1. Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

2. Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

**PATIENT AGREEMENTS AND AUTHORIZATIONS**

1. I authorize treatment for myself or the person named above.
2. I agree to pay all fees and charges for medical services rendered by Visalia Eye Center upon presentment of statement, unless credit arrangements are agreed upon in writing. The amount stated as due shall be deemed as correct and reasonable unless protested in writing within thirty days of the statement date.
3. All proceeds of insurance are assigned to Visalia Eye Center where coverage exists, but Visalia Eye Center does not assume the responsibility for collection of insurance benefits (A copy of this assignment is valid as the original).
4. In the event attorney's fees or court costs are incurred to collect an unpaid balance due for medical services, I agree to pay such fees and costs in addition to any other amount due.
5. I authorize Visalia Eye Center to release any medical information about me to the Health Care Financing Administered/ Insurance Company and its agents needed to determine these benefits payable to related services.
6. MEDICARE Patients: In Medicare assigned cases, the physician, or supplier agrees to accept the charge determination of the Medicare carrier as the full charge. The patient is responsible only for the deductible, co-insurance, and non-covered services. The co-insurance and the deductible are based upon the charge determination of the Medicare carrier.
7. HMO Patients: Some insurance companies have determined that if the insurance company or the primary care physician does not provide authorization prior the office visit, they may deny payment. The Visalia Eye Center will submit for retroactive authorization on my behalf, but should it be denied, I understand that I am financially responsible for all charges incurred.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_