Eye Physicians & Surgeons, Inc.

Patient Demographic Information

Last Name: _____ **First Name**: _____ MI: ____

Street Address: _____

City: _____ **State**: _____ **Zip**: _____

Home Phone: (_____) _____-_____

Work Phone: (_____) _____-_____ ext #: _____

Cell Phone: (_____) _____-_____

Social Security Number: _____-_____-_____ Sex (circle): Male Female

Marital Status (circle): Single Married Divorced Widowed

Date of Birth: _____/_____/_____

Email address: _____

Employment Status (circle): Full-time Part-time Retired

Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Student Status (circle): Full-time Part-time

Referred by: _____

RESPONSIBLE PARTY INFORMATION

If the patient is the person responsible for paying any out of pocket expense, please mark "self" and turn over to sign the Assignment and Release statement.

Patient's relationship to the responsible party (circle): Self Spouse Child

Last Name: _____ First Name: _____ MI: ____

Street Address: _____

City: _____ State: _____ Zip: _____

Work Phone: (_____) _____-_____ ext_____

Social Security Number: _____-_____-_____ Sex (circle): Male Female

Date of Birth: _____/_____/_____

Employment Status (circle): Full-time Retired

Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION

I authorize payment directly to Eye Physicians & Surgeons, Inc. of any medical/testing benefits otherwise payable to me by my insurance carrier for services as described. Also, I hereby authorize the release of any information obtained in the course of my registration, interview, examination and treatment, necessary to file a claim with my insurance carrier(s), collect any balance due or deemed necessary pursuant to State or Federal law, statute or regulation.

NON-COVERED SERVICES

I accept responsibility for paying any monies not paid by my insurance carrier for a balance due, except that dollar amount which is limited by agreement between Eye Physicians & Surgeons, Inc. and the insurance carrier. Furthermore, I acknowledge that it is my responsibility to obtain any necessary healthcare care service plan authorizations/referrals before my visit takes place. Moreover, I agree that it my responsibility to contact my insurance carrier to confirm if Drs. Essepian and McCabe are in my insurance network and/or plan, before my visit takes place. If I fail to do so, I accept that this visit will be a non-covered service, and I will be responsible for any and all charges related to my visit.

PRACTICE FINANCIAL POLICIES

I have read and agree to the full Patient Financial Policy of Eye Physicians and Surgeons, Inc., part of which is summarized here. I recognize that payment for all co-pays, deductibles, co-insurances and other pre-determined out-of-pocket expenses are expected at time of service. I acknowledge that it is my responsibility to know the amount of my out-of-pocket expenses and I agree to check with my insurance carrier before each visit to confirm any changes. I recognize that failure to pay these out-of-pocket expenses at time of service will lead to a **ten dollar ($10) administrative service charge**. I recognize that Eye Physicians & Surgeons, Inc. reserves the right to charge me for missed appointments and will bill my account for finance charges at the rate of 1.5% per month (18% per annum) on my balance(s) after a period of ninety (90) days from the date of service. In the event that my account is placed in the hands of a collection agency or attorney for collection, I agree to pay all costs and expenses related to the collection thereof. A copy of my signature consenting to this agreement is as valid as the original, and shall continue to be valid for one year from the date of signature.

_____ _____/_____/_____

Patient/Responsible Party Signature Date of Signature