

**MILWAUKEE EYE CARE ASSOCIATES, S.C.**  
**PATIENT INFORMATION**

\_\_\_ Female  
\_\_\_ Male

Please Print Clearly

Year

20 \_\_\_\_ 20 \_\_\_\_  
20 \_\_\_\_ 20 \_\_\_\_  
20 \_\_\_\_ 20 \_\_\_\_  
20 \_\_\_\_ 20 \_\_\_\_

Mr. \_\_\_ Mrs. \_\_\_ Ms. \_\_\_ Miss \_\_\_ Dr. \_\_\_ Other \_\_\_

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Last Name                      First Name                      M.I.                      Date of Birth (DOB)

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Home Address                      City                      State                      Zip Code

\_\_\_\_\_ Email: \_\_\_\_\_

Mailing Address (if different)

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Occupation or Former: \_\_\_\_\_ Patient's Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Employer: \_\_\_\_\_ Location: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policyholder's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Second/Supplemental Insurance: \_\_\_\_\_ Policyholder's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**GUARANTOR (Person responsible for the bill – if different from patient):**

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Last Name                      First Name                      M.I.                      Date of Birth

Guarantor Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Phone: \_\_\_\_\_

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Address                      City                      State                      Zip Code

Relationship to Patient: \_\_\_\_\_

## PATIENT RIGHTS AND RESPONSIBILITIES

- **Medicare – ASSIGNMENT OF BENEFITS:** I request that payment of authorized Medicare benefits be made on my behalf to Milwaukee Eye Care Associates, S.C., for any services furnished me by that provider(s). I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

This authorization is in effect until I choose to revoke it. \*

\*If you are a patient in a hospital or skilled nursing facility, this authorization is in effect for the period of your confinement.

- **All Other Insurance**
  1. **ASSIGNMENT OF BENEFITS:** I authorize my insurance company to assign benefits to Milwaukee Eye Care Associates, S.C.
  2. **RESPONSIBILITY FOR PAYMENT/PATIENT AGREEMENT:** I understand that the doctors at Milwaukee Eye Care Associates, S.C., are not responsible for deductibles made by any insurance company, government agency, HMO/PPO plan, etc. I agree to pay any portion of the fees charged by Milwaukee Eye Care Associates, S.C., for services rendered to me that are not covered by my insurance..
  3. **RELEASE OF INFORMATION:** I hereby give my consent to Milwaukee Eye Care Associates, S.C., to release any information regarding my care and treatment as may be required by any insurance carrier for any portion of my bill.
  4. **RETURN CHECK:** I understand that a \$20.00 return check fee will be added to my account along with the original amount of the check if my check is returned to Milwaukee Eye Care Associates, S.C.
- **Privacy Policy – Health Information Protection & Privacy Act (HIPAA): – ACKNOWLEDGEMENT OF RECEIPT:** I acknowledge that I have been offered a copy of MECA’s notice of privacy practices.

I have read and understand the above.

\_\_\_\_\_ Date

\_\_\_\_\_  
Patient or guarantor signature

Relationship to Patient: \_\_\_\_\_