MILWAUKEE EYE CARE ASSOCIATES, S.C.
PATIENT INFORMATION

Year
20 ___ 20 ___
20 ___ 20 ___
20 ___ 20 ___
20 ___ 20 ___

_____ Female

_____ Male

Please Print Clearly

Mr. ___ Mrs. ___ Ms. ___ Miss ___ Dr. ___ Other _____

			/ /
Last Name	First Name	Middle Initial	Date of Birth (DOB)

Mailing Address	City	State	Zip Code

Patient's Social Security Number: _____ - _____ - _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Employer: _____ Occupation or Former: _____

Primary Care Physician: _____ Phone: _____

How did you hear about our office? _____

Emergency Contact: _____ Phone: _____

INSURANCE INFORMATION

Primary Medical Insurance: _____

Policy Holder's Name: _____ Relationship: _____ DOB: _____

Secondary/Supplemental Medical Insurance: _____

Policy Holder's Name: _____ Relationship: _____ DOB: _____

Vision Insurance: _____

Policy Holder's Name: _____ Relationship: _____ DOB: _____

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

			/ /
Last Name	First Name	Middle Initial	Date of Birth (DOB)

Guarantor Social Security Number: _____ - _____ - _____ Phone: _____

Address	City	State	Zip Code

Relationship to Patient: _____

(OVER – READ AND SIGN)

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 to 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.

ASSIGNMENT OF BENEFITS: I authorize my insurance company to assign benefits to Milwaukee Eye Care Associates, S.C.

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 company.

FINANCIAL RESPONSIBILITY DISCLOSURE: I understand and agree that services have been rendered *for which I am fully responsible*, whether or not medical or other insurance should cover the cost of at least a portion of the services rendered, and I further understand and agree that in the event that I default on any payments due and owing Milwaukee Eye Care Associates, S.C. For such services, *I will pay any and all costs of collection* of such payment due and owing.

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.

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 Insurance Protection & Privacy Act (HIPAA): - ACKNOWLEDGEMENT OF RECEIPT: I acknowledge that I have been offered a copy of Milwaukee Eye Care Associates, S.C. notice of privacy practices.

I have read and understand the above.

_____ / / _____

Patient or Guarantor Signature Date

Relationship to Patient: _____