

## Patient Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Gender: Male Female Social Security #: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

## Responsible Party Information

Person Responsible for Account \_\_\_\_\_  
Relation to Patient \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ D.O.B. \_\_\_\_\_  
Address (if different from patient) \_\_\_\_\_

## Insurance Information

Primary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group# \_\_\_\_\_  
Secondary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group# \_\_\_\_\_

## Financial Authorization

I hereby give my consent to Shippee Family Eye Care or any doctors at this location to provide eye care services to myself and/or any party for whom I am legally responsible. I understand that I am ultimately responsible, regardless of my insurance status, for any charges incurred by me or any party for whom I am legally responsible.

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

## Information Authorization

I authorize use of this signature for all my insurance submissions. I authorize payment of benefits directly to my doctor, I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

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

## Medicare Waivers

I understand that Medicare does not pay for service code 92015 "Refraction". I will be responsible for this charge of \$22.00. I understand that Medicare does not pay for glasses except for the first pair following Cataract surgery.

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

## Acknowledgement of Privacy Policy

I acknowledge that I have viewed and been offered a copy of the privacy policy for Shippee Family Eye Care.

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