PERSONAL INFORMATION (Please complete each area)

Today's Date______________________________

Patient's Legal Name____ Date of Birth________________________

Home Address____________________________________City______________________ State__________ Zip__________

Social Security Number____________________________ Sex M___ F___ Age_______ Occupation____________________

Home Phone Number ( )____________________ Work Phone / Cell or Pager Number ( )____________________

Alternate Phone Number ( )______________________ Marital Status: Single___ Married___ Divorced___ Widowed___

Employer's Name______________________________ Employer's Address__________________________________

How did you hear about our practice?____

Is this exam due to a work related accident? Yes ____ No ____ (If yes, please see receptionist for additional information)

Is there anyone, other than your doctor, with whom we can discuss your private health information? (Please circle) YES NO
For example, your family may have questions regarding your care, billing or appointments; with whom may we speak?

Name(s)____ Phone Number ( )______________________

Relationship to you: Spouse___ Adult Child___ Other (please specify)____

If you answered NO in the previous question, please provide Emergency Contact Information. In case of emergency contact:

Name ________________________ Phone Number ( ) ________________ Relationship to you____________________

PHYSICIAN INFORMATION

***Required for correspondence to your Primary Care Physician**

Primary Physician's Name______________________________________ Phone Number ( )____________________

Address____________________________________City______________________ State__________ Zip__________

VISION INSURANCE

Do you have specific vision insurance such as, **VISION SERVICE PLAN**? (Please circle) YES NO
If so, please provide Plan name, ID#/SSN, Date of Birth & Policy Holders name.

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MEDICAL INSURANCE

This section must be completed in addition to providing a current insurance card.
WE CANNOT FILE A CLAIM WITHOUT AN INSURANCE CARD.

Primary Insurance ________________________________ Secondary Insurance ________________________________

Policy Holder's Name ______________________________ Policy Holder's Name ______________________________

Policy Holder's ID#/SSN ____________________________ Policy Holder's ID#/SSN____________________________

Policy Holder's Date of Birth__________________________ Policy Holder's Date of Birth__________________________

FINANCIAL RESPONSIBILITY

If the patient is a minor (under the age of 18) or someone other than the patient has legal responsibility, (i.e. attorney, trustee, POA, or former spouse) please provide us with a copy of the appropriate court order and/or the name and certificate number of the appropriate health insurance, and complete the following:

Name of Responsible Party____ Phone Number ( ) ____________________

Address____________________________________City______________________ State__________ Zip__________

Relationship to patient____

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS & FINANCIAL AGREEMENT

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Northwest Eye Surgeons (NWES), for services furnished me by NWES. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. NWES accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere in other approved forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made in my behalf to NWES, if possible or otherwise to me.

3. REFERRAL & CO-PAYMENT: I understand if I am covered by an HMO (Including Medicare HMO) that requires a REFERRAL from a Primary Care Physician, I am responsible for obtaining that referral and assuring its arrival in this office. **Northwest Eye Surgeons is not responsible for contacting the Primary Care Physician or obtaining that referral.** If my referral is not in this office at the time of my appointment, I will be asked to sign a Waiver of Insurance Liability, making the patient financially responsible for all charges incurred. These charges are to be paid at the time of service. All co-payments are required at the time of service. Failure to do so can be a violation of my insurance coverage agreement.

4. RELEASE OF INFORMATION: NWES may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to NWES for reimbursement for services rendered, and (2) any health care provider for continued patient care. NWES may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy if this authorization may be used in place of the original.

5. OTHER INSURANCE: Northwest Eye Surgeons participates in a variety of insurance contracts. I understand I am responsible for contacting my insurance carrier directly for information on covered services or providers. I understand that I am obligated to pay the full charges of all services rendered to me by NWES if I belong to a plan that NWES is not contracted with.

6. NON-COVERED SERVICES: I understand that NWES' contracts with health care service plans (i.e. HMOs, PPOs) relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plan not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with NWES to obtain necessary health care service plan authorizations.

7. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by NWES, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to NWES for payment. All benefits under the patient's insurance policies, or any other party liable to the patient, are hereby assigned to Northwest Eye Surgeons. I also understand that by signing below I agree to pay any and all charges on my account that are not covered or have been deemed Patient Responsible by my insurance company. These charges may include but are not limited to co-payments, deductibles, coinsurance, and vision services (such as **REFRACTIONS** and contact lens services). I understand that if I fail to provide valid, current insurance information to Northwest Eye Surgeons before the filing limit, I am responsible for all charges incurred.

______________________________ ______________________

Patient Signature or Authorized Party Date 5/07

For Office Use Only:

Date Updated /	Initials	Date Updated /	Initials	Date Updated /	Initials	Date Updated /	Initials