

Mann Eye Institute

Date: _____

Mr. Mrs. Ms. Miss

Patient's Name: _____
Last First MI

Address _____
City State Zip

Sex: M F Date of Birth: _____ E-mail: _____

Phone # _____ Alternate # _____

Driver's License # _____ SS # _____

Employer: _____ Phone # _____

Family Physician: _____ Phone # _____

Referring Physician: _____ Phone # _____

In case of emergency, please contact _____ Phone # _____

Name of insurance company to be filed _____

Co-pay/deductible/co-insurance/refraction to be paid by: cash check credit card

Person Responsible for Payment (Check one): Self Spouse Parent Guardian

If other than patient, please complete the following: Phone # H _____ W _____

Name _____ SS # _____ DOB: _____

Address _____ City _____ State _____ Zip _____

If Workman's Compensation, check here, and give name and phone number of the person to contact for verification of coverage. _____

HMO programs require that you see a physician in their network and you will be responsible for an office co-payment and necessary referrals.

I hereby consent to a health examination, related diagnostic procedures and treatments provided by Mann Eye Institute. I also authorize the use of any photographs or data collections taken to document my ocular condition for routine care or use in research and professional publication. Photostatic copies of this authorization will be considered valid as the original.

Payment is due at the time services are rendered. For your convenience we accept the following forms of payment:
MasterCard, Visa, American Express, Discover, Personal Check, Cash

Signature _____
(Please circle one) Patient Parent Legal Guardian Responsible Party

Mann Eye Institute and Laser Center

Signature on File, Assignment of Benefits, Financial Agreement, HIPAA Notice

Name: _____

Date: _____

- 1. MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Mann Eye Institute for services furnished me by Doctor(s). I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or 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 CMS 1500 form, my signature authorizes releasing the information to the Insurer or agency shown. Mann Eye Institute accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered 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 HCFA1500 form, my signature authorizes release of the Information to the insurer or agency shown. I request that payment of authorized secondary Insurance benefits be made on my behalf to Mann Eye Institute, if possible or otherwise to me.
- 3. OTHER INSURANCE:** I authorize payment of my medical and surgical insurance benefits to Mann Eye Institute. I understand I am financially responsible for any charges whether or not paid by said Insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Mann Eye Institute. I authorize Mann Eye Institute to release any Information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.
- 4. NON-COVERED SERVICES:** I understand that Mann Eye Institute's contract with health care services plans (i.e., HMOs, PPOs) relates only to items and services which are "covered" by the health care service plans. Accordingly, I accept full financial responsibility for all Items or services, which are determined by the health care service plans not to be covered, including the refraction fee. I agree to cooperate with Mann Eye Institute to obtain necessary health care service plan authorizations.
- 5. FINANCIAL AGREEMENT:** I agree that in return for the services provided to me by Mann Eye Institute, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Mann Eye Institute for payment. If my account is sent to an agency for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance are hereby assigned to Mann Eye Institute. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Mann Eye Institute. However, I understand that I am primarily responsible for the payment of my bill.
- 6. HIPAA NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have received the Notice of Privacy Practices issued by Mann Eye Institute that was effective April 14, 2003. I agree to allow electronic communication as defined in security practices effective April 21st, 2005.

Signature _____