PATIENT INFORMATION

Today's Date: _____

Last Name: _____First Name:_____ Initial: _____

Address: _____City: _____ State: ___ Zip: _____

Phone Numbers:

Home ( )_____ Work: ( )_____ Cell/Beeper: ( )_____

Sex: ____ Social Security Number: _____Date of Birth:_____

Single___Married___Divorced___Widowed___ Name of Spouse_____

Insurance Information: (Only fill out this section if different from patient)

Name of Insured:_____ Relationship to Pt:_____

Social Security # of Insured:_____ D.O.B of Insured:_____

Person responsible for bill (other than patient):_____

Employer Information:

Employer: _____ Occupation:_____

Emergency Contact Information:

Name: _____ Relationship:_____

Phone #:_____ Address:_____

I REALIZE THAT I AM RESPONSIBLE TO PAY ANY NON-COVERED SERVICES AND/OR CO-PAYMENTS – PAYABLE AT THE TIME OF SERVICE.

**This includes an eyeglass refraction fee of $50 or a contact lens/eyeglass refraction fee of $70. The refraction is a vision service (glasses/contact lenses) not covered by health insurance companies and will not be billed. However, this may be covered if I have a separate vision policy and I understand I am responsible for that filing. I understand that all out-of-pocket/non covered services are due at the time of service.

**It is my responsibility to provide this office with current up-to-date insurance information. This office will make every attempt to collect from my insurance company, but if no response, I will be responsible for any uncollected monies due past 60 days of visit. Any accounts turned over for collections, will incur a $25.00 collection fee as well as collection charges and credit reporting. I agree to pay all fees associated with collection of my bill/balance

Patient or HCR Signature: X_____ Date: _____

ALL PATIENT MUST SIGN/HEALTH INSURANCE CLAIM AUTHORIZATION

** I request that payment of authorized Medicare and/or Medigap benefits, AND ALL COMMERCIAL HEALTH INSURANCE PLANS be made on my behalf to Erik S. Barrett, M.D./Barrett Eye Care LLC for any services furnished me by him. 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.

Patient or HCR Signature: X_____ Date: _____

PLEASE TURN OVER

1/2018