Lakeshore Eye Specialists, PC

PATIENT INFORMATION			
Last Name	First Name & Initial		
Address 1			
Address 2			
City	State	Zip Code	
Home Phone	Sex: F / M	**Birthdate:**	Age
Marital Status M/S/W/D		cell phone:	
Patient's Social Security #		email:	
Patient's Employer			
Employer Address			
City	State	Zip Code	
Employer's Phone	Ext		
Who Referred You Here Today?		Family Physician:	
GUARANTOR / SPOUSE INFORMATION			
Responsible Party Last Name			
Responsible Party First Name & Initial		Relationship to Patient	
Address			
City	State	Zip Code	
Home Phone	Cell Phone		
Birthdate	Responsible Party Social Security #		
Employer	Employer Phone	Ext	
Employer Address	City	State	Zip Code
INSURANCE #1:			
Policy Holders Last Name		First Name & Initial	
Relationship to Patient:			
Effective Date of the Policy	**Birthdate:**	**Social Security:**	
INSURANCE #2:			
Policy Holder Last Name		First Name & Initial	
Relationship to Patient:			
Effective Date of the Policy	**Birthdate:**	**Social Security:**	
Is your condition a result of an injury at work?	Yes No	Date of Injury:	Claim#
Is your condition a result of an auto accident?	Yes No	Date of Accient:	Claim#
INCOMPLETE OR INACCURATE COMPLETION WILL RESULT IN PAYMENT DUE FROM YOU			

For your protection, we will ask to make a copy of your drivers license. Incidents of health Insurance fraud have been reported in which theft or deception of one's coverage has occurred.
We cannot discriminate, we must make this request to all patients. Please do not be offended.

YOU MUST READ AND SIGN THE OTHER SIDE OF THIS FORM Today's Date:_______________

CONSENT TO TREAT: I request and give consent to Lakeshore Eye Specialists, PC to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by Lakeshore Eye Specialists, PC for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

INITIAL________________________

RELEASE OF MEDICAL INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS:
I authorize Lakeshore Eye Specialists, PC or a member of the staff to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to Lakeshore Eye Specialists, PC, on my behalf.

INITIAL________________________

FINANCIAL AGREEMENT: I agree to pay Lakeshore Eye Specialists, PC for all services, treatments, and supplies provided to me by its Physicians, Nurses, Assistants, and Employees at the time of services or as contracted with my insurance. I assign directly to Lakeshore Eye Specialists, PC the payment of my health insurance benefits, which are due for these services, treatments and supplies. I understand that no adjustment or discount will be made if my insurance company does not pay according to the managed care contract or the State of Indiana law (requires payment of an electronic claim within 30 days and a paper claim within 45 days). The Indiana law will supersede a contract agreement. I certify that the information given by me in applying for payment under Title XVIII (Medicare) and / or Title XIX (Medicaid) of the Social Security Act is true and correct. If I fail to pay for these services, I agree to pay the collection agency fees, attorney fees and court costs incurred in collecting the debt. A finance charge of 1.5% monthly (18% annum) will be applied to any unpaid balance over 30 days old. If I am a Medicaid recipient and request and receive services for which Medicaid will not pay, I understand I must pay for those services.

PATIENT'S SIGNATURE:____ DATE:_________

Parent / Guardian:____ DATE:_________

Have you given anyone **POWER OF ATTORNEY?**: Yes____ No____ If Yes, Please list the name of that person:

Name:________________________________Relationship:____________________Date:___________

A legal copy will be required in the office. Date Received: _____________________By:_____________

RELEASE OF PROTECTED HEALTH CARE INFORMATION VIA
TELEPHONE TO ANSWERING MACHINE OR VOICE MAIL

I give my consent and authorization for the Medical, or Billing Staff of Lakeshore Eye Specialists, PC to leave protected health care information about me or for me on my answering machine or voicemail via the telephone at the number I have listed below. I understand I may revoke the privilege at any time by submitting my request in writing to the office. If I choose not to authorize release via the telephone, I understand, I am responsible to call the office to retrieve results of all tests and procedures.

Phone number:________________________ Signature:____

Restriction:____

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