Holdrege Family Vision Clinic

HOLDREGE FAMILY VISION CLINIC, P.C

Date:_____

NAME: LAST_____FIRST_____MIDDLE INITIAL_____

BIRTHDATE_____ MARITAL STATUS: __SINGLE __MARRIED __WIDOW SS #_____

PHONE: (HOME) _____(CELLULAR)_____GENDER: ____MALE____FEMALE

MAILING ADDRESS:_____CITY/STATE/ZIP_____

STREET ADDRESS:_____ EMAIL:_____

FAMILY PHYSICIAN:_____ADDRESS:_____

EMPLOYER:_____ADDRESS:_____

OCCUPATION:_____WORK PHONE:_____

PERSON RESPONSIBLE FOR FAMILY BILLING: _____SELF_____SPOUSE_____PARENT____GUARDIAN

NAME:_____RELATIONSHIP:_____
ADDRESS: (IF DIFFERENT THAN PATIENT)_____
EMPLOYER:_____PHONE NUMBER:_____

NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU (EMERGENCY CONTACT)

NAME:_____RELATIONSHIP_____
ADDRESS:_____PHONE:_____

Due to new privacy laws, Holdrege Family Vision Clinic, P.C. is unable to speak to anyone regarding a patient's care. However, we realize that most patients want certain family members or friends to help them with their healthcare needs and financial billing. Therefore, we must have you indicate who we can talk to regarding these issues. You do not need to list your family doctor or insurance company since the laws allow us to speak with them unless you complete a form asking us not to. Please list below who you wish to have access to your personal health information.

NAME:_____RELATIONSHIP:_____PHONE NUMBER:_____

NAME:_____RELATIONSHIP:_____PHONE NUMBER:_____

NAME:_____RELATIONSHIP:_____PHONE NUMBER:_____

INSURANCE INFORMATION-(If you have your insurance cards with you, we will be happy to make a copy and you can skip this section)

_____MEDICARE NUMBER:_____ _____MEDICAID NUMBER:_____
_____WORKMAN'S COMPENSATION DATE OF INJURY:_____
NAME OF WORKMAN'S COMPENSATION INSURANCE:_____
ADDRESS:_____WHO CAN VERIFY ACCIDENT:_____

OTHER INSURANCE

COMPANY:_____POLICY NUMBER:_____GROUP:_____
ADDRESS:_____CITY/STATE/ZIP:_____
SUBSCRIBER:_____RELATIONSHIP TO PATIENT:_____
EMPLOYER OR POLICY HOLDER:_____

PLEASE COMPLETE BACK SIDE OF THIS FORM

ALL MEDICARE PATIENTS PLEASE COMPLETE-Medicare Secondary Payor Questionnaire(If you do not have Medicare please skip to the next section.)

Are you a Veteran? ____YES ____NO
Did the VA refer you here for treatment? ____YES ____NO
Do you have a VA "Fee Basis" ID Card? ____YES ____NO
Do you have a Federal Black Lung Card? ____YES ____NO
Are you covered by an employer's health insurance plan through your employment or that of a family member? (Not retiree Coverage) ____YES ____NO
Is this medical condition due to an accident of any kind? ____YES ____NO
(If you answered yes, please complete the following)
____Work Related
____Auto
____ Injured In Your Home
____Other

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Holdrege Family Vision Clinic, P.C., for services furnished to me by Holdrege Family Vision Clinic, P.C. 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 information to the insurer or agency shown. Holdrege Family Vision Clinic, P.C. accepts the charge determination of the Medicare Carrier as the full charge, and I am responsible only for the 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 on other approved claim 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 on my behalf to Holdrege Family Vision Clinic, P.C., if possible or otherwise to me.
3. **RELEASE OF INFORMATION:** Holdrege Family Vision Clinic, P.C. 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 Holdrege Family Vision Clinic, P.C. for reimbursement for services rendered, and (2) any health care provider for continued patient care. Holdrege Family Vision Clinic, P.C. 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 of this authorization may be used in place of the original.
4. **OTHER INSURANCE:** I understand that Holdrege Family Vision Clinic, P.C. maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that Holdrege Family Vision Clinic, P.C. has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Holdrege Family Vision Clinic, P.C. if I belong to a plan that does not appear on the above mentioned list.
5. **NON-COVERED SERVICES:** I understand that Holdrege Family Vision Clinic, P.C.'s 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 plans 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 or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Holdrege Family Vision Clinic, P.C. to obtain necessary health care service plan authorizations.
6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Holdrege Family Vision Clinic, P.C., I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Holdrege Family Vision Clinic, P.C. for payment. If an account is sent to an attorney 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 insuring the patient, or any other party liable to the patient, is hereby assigned to Holdrege Family Vision Clinic, P.C. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Holdrege Family Vision Clinic, P.C. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

_____ _____
Beneficiary Signature or Authorized Party Date