

**PATIENT INFORMATION****This form must be completed IN FULL before the doctor sees you.****LEGAL NAME:****SEX: M / F**

Last	First	Middle
Mailing Address:		

City	State	Zip	
SSN:	Date of Birth:	Age:	Marital Status: M S W D

Patient Home Phone:	Patient Cell Phone:
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Patient Employer:	Patient Work Phone
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**PATIENT EMAIL ADDRESS**

Emergency contact person not living with you      Phone

**SPOUSE, PARENT, GUARANTOR, AND/OR PERSON RESPONSIBLE FOR PAYMENT**

Legal Name:	Relationship to Patient:	SEX: M / F
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Last	First	Middle	
Mailing Address:			email address:

Home Phone:	Cell Phone:
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Employer:	Work Phone:
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SSN:	Birth Date:	Age:	Marital Status:
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I certify this information is true and authorize release of medical information necessary to report a claim to my plan. I authorize my physician to receive payment from my insurance. **I understand I am financially responsible for any balance not covered by my insurance plan.** A copy of this signature is valid as the original. If there is no insurance, payment is due at time of service.

**PLEASE SIGN HERE:**

Signature of patient, parent, guardian, or authorized person.	Relationship to patient	Date
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Address of person signing this form	Phone number of person signing this form
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**MEDICARE PATIENTS**

I request that payment of authorized Medicare benefits be made on my behalf to The Eye Clinic of Sandpoint for any services furnished to me by The Eye Clinic of Sandpoint. I authorize any holder of medical information about me to release to The Centers For Medicare and Medicaid Services (formerly Health Care Financing Administration) any information needed to determine these benefits payable to 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 coverage is indicated in item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare-assigned cases, The Eye Clinic of Sandpoint agrees to accept the charge determination of the Medicare carrier as 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.

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**Print Patient Name**

<b><u>Signature</u> of patient or authorized person.</b>	<b>Date</b>
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