Mountain Empire Eye Physicians

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TODAY'S DATE _____

PATIENT'S NAME _____ AGE _____ SOCIAL SECURITY # _____

MAILING ADDRESS _____

CITY/STATE/ZIP _____ DATE OF BIRTH _____

CONTACT NUMBER(S): Primary Phone Number: _____ Type: Landline Cell Work

Alternate Phone Number: _____ Type: Landline Cell Work

MAY WE CONTACT YOU AT WORK? YES NO MAY WE CONTACT YOU ON YOUR CELL PHONE? YES NO

EMAIL ADDRESS: _____

SEX _____ MALE _____ FEMALE _____ SINGLE _____ MARRIED _____ DIVORCED _____ WIDOWED

IF MARRIED, NAME OF SPOUSE _____

RACE (Circle One) WHITE BLACK AMERICAN INDIAN ASIAN or PACIFIC ISLANDER OTHER

ETHNICITY (Circle One) HISPANIC NON-HISPANIC UNKNOWN

PATIENT'S OCCUPATION: _____ EMPLOYER: _____

PRIMARY INSURANCE NAME: _____ INSURED: (circle) SELF SPOUSE PARENT

SECONDARY INSURANCE NAME: _____ INSURED: (circle) SELF SPOUSE PARENT

IN CASE OF EMERGENCY, WHO WE MAY CONTACT? _____

EMERGENCY NUMBER #1: _____ EMERGENCY NUMBER #2: _____

NAME OF PRIMARY CARE PHYSICIAN: _____ CITY, STATE _____

WERE YOU REFERRED TO OUR OFFICE? IF YES, BY WHOM? _____

****IF PATIENT IS A MINOR, PROVIDE NAME OF PARENT OR GUARDIAN:** _____

*****PLEASE PROVIDE RECEPTIONIST WITH INSURANCE CARD(S)*****

(CONTINUED ON BACK OF FORM)

Mountain Empire Eye Physicians

PATIENT AUTHORIZATION

ASSIGNMENT OF BENEFITS

Patient Name: _____ DOB: _____

I request that payment of authorized **Medicare** benefits be made on my behalf to Mountain Empire Eye Physicians, PLLC (MEEP) for services furnished me by MEEP, any audiologist. or any physician of the group. I authorize any holder of medical information related to my healthcare to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine applicable benefits payable for services provided by MEEP, any audiologist, or any physician of the group. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare contractor.

I also request that the payment of any authorized **Medigap** benefits or other secondary insurance be made on my behalf to Mountain Empire Eye Physicians, PLLC, any audiologist, or any physician of that group, for services provided to me. I authorize any holder of medical information related to my healthcare to release to my Medigap insurer or other commercial payer (where applicable) any information needed to determine applicable benefits payable for services provided by MEEP, or any physician or audiologist of the group.

My signature below further verifies if that I have joined an HMO or other entity in which my Medicare benefits have been relinquished, I agree to be bound by the terms and policies of the Medicare replacement HMO product.

I also request that the payment of any **commercial or third-party insurance** (if applicable) be made on my behalf to Mountain Empire Eye Physicians, PLLC, any audiologist, or any physician of that group, for services provided to me. I authorize any holder of medical information related to my healthcare to release to my insurer or other commercial payer (where applicable) any information needed to determine applicable benefits payable for services provided by MEEP, any audiologist, or any physician of the group.

I understand I am responsible for any deductible, co-pay, co-insurance and/or any non-covered procedures. I further understand that I am responsible for making sure that any referral authorization needed from my primary care physician is obtained prior to my visit in this office. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Patient or Guardian Signature: _____

Date: _____