STEVEN G. WISEHART, MD WILLIAM C. ACKERMAN, JR., MD

ADVANCED EYE CENTER

Date: ___________________________

Patient's Full Name: ____

Date of Birth ___________________ Age: ______________ Male/Female

Address: ______________________________________ Apt #: _________________

City, State, Zip: _________________________ Social Security #: ______________

Home Phone #: ( ) ____________________ Work Phone #: ( ) _______________

Employer: ____

Spouse or Parent's Name: _______________________ Phone #: ( ) ___________

Person to contact in emergency other than Spouse or Parent: _____________________

Home Phone #: ( ) _____________________ Work Phone #: ( ) _____________

PLEASE GIVE US YOUR INSURANCE CARD TO COPY

Is this visit work related? ________________________________ Date of Injury: _______
How did accident occur? ____

Medicare Beneficiary Name _____________________ Medicare #: ______________

I request that payment of authorized Medicare benefits be made on my behalf to Advanced Eye Center, for services furnished me by Advanced Eye Center. 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 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 or MEDIGAP is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made either to me or on my behalf to Advanced Eye Center.

Advanced Eye Center accepts the charge determination of the Medicare carrier as the full charge, and the patient is responsible only deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

___________________________________ ______________________________

Beneficiary Signature Date

OTHER INSURANCE

I hereby authorize payment of my medical and surgical insurance benefits to Advanced Eye Center. I understand I am financially responsible for any charges whether or not paid by said insurance. If copayments and /or deductibles are designated by my insurance company or health plan, I agree to pay them to Advanced Eye Center. I authorize Advanced Eye Center to release any information required to process any and all claims for reimbursement on my behalf. A copy of the authorization may be used in place of the original.

___________________________________ ________________________________

Beneficiary Signature Date