

## NEW PATIENT INFORMATION

Welcome to our office. Please complete this form and return it to our receptionist along with a copy of your current photo identification card and insurance card(s). Your information is **confidential** and will not be released without your authorization.

NAME \_\_\_\_\_ Date \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Home Phone \_\_\_\_\_

Mobile Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Please circle one: Minor Single Married Divorced Widowed Separated

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Spouse/Guardian \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Insured's  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Do you have Medical Insurance? ( ) YES ( ) NO.

### **Authorization to Release and Assign Insurance Benefits**

I hereby authorize the above doctor(s) to furnish the insured's insurance company all information which said insurance company may request concerning my claim.

I hereby assign to the doctor all money to which I am entitled for expenses relative to the services performed from time to time, but not to exceed my indebtedness to said doctor. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me. I understand that I am financially responsible to said doctor for charges. In the case of default on payment of this account, I agree to pay all collection costs, attorney fees, and court costs incurred in attempting to collect on the outstanding balance.

### **Office Financial Policies**

Payment is expected at the time of service. This includes all co-pays, deductibles and outstanding balances. For your convenience, we offer the following methods of payment.

**CASH CHECK CREDIT CARDS: MASTERCARD VISA DISCOVER**

**\*\*\*There is a \$35<sup>00</sup> fee for a check returned by the bank for any reason.\*\*\***

### **Missed Appointment Policy**

If you cancel your appointment without a **48 hour** notice or do not keep your appointment you will be charged a **\$50<sup>00</sup> No Show Fee**.

If you cancel your surgery appointment, to include cataract surgery, any laser procedure or in-office procedure, without a **48 hour** notice, or fail to keep your appointment, or have your surgery cancelled as a result of eating or drinking prior to your procedure, you will be charged a **\$100<sup>00</sup> No Show Fee**.

Your signature below signifies your understanding, acceptance and agreement to our office policies.

\_\_\_\_\_  
Responsible Person's Signature

\_\_\_\_\_  
Date

**\*\*Patient records only maintained for six (6) years after last encounter (visit).**