

PATIENT DEMOGRAPHIC INFORMATION

PLEASE PRINT CLEARLY

COMPLETE ALL INFORMATION

PATIENT'S FULL NAME _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____
 HOME PH. (____) _____ WORK. PH (____) _____ MARITAL STATUS _____
 CELL PH. (____) _____ EMAIL _____
 SSN _____ DATE OF BIRTH _____ AGE _____ SEX _____
 PRIMARY PHYSICIAN _____ PHYSICIAN PHONE# _____
 MEDICINE ALLERGIES _____

BILLING INFORMATION

FULL NAME OF PERSON TO BE BILLED _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____
 PHONE (____) _____ SSN _____ DATE OF BIRTH _____
 EMPLOYER NAME _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP CODE _____
 PHONE (____) _____

FULL NAME OF SPOUSE _____
 SSN _____ DATE OF BIRTH _____

INSURANCE INFORMATION

MEDICARE # _____ MEDICAID # _____ STATE _____
 NAME OF INSURANCE CO. (PRIMARY) _____
 ID# _____ GROUP # _____ POLICY # _____
 NAME OF POLICY HOLDER _____
 RELATIONSHIP TO PATIENT _____
 ADDRESS OF INSURANCE CO. _____

NAME OF INSURANCE CO. (SECONDARY) _____
 ID# _____ GROUP # _____ POLICY # _____
 NAME OF POLICY HOLDER _____
 RELATIONSHIP TO PATIENT _____
 ADDRESS OF INSURANCE CO. _____

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THIS PRACTICE'S NOTICE OF PRIVACY PRACTICES.
 I ACKNOWLEDGE THAT I WILL BE FINANCIALLY RESPONSIBLE FOR ANY SERVICES DEEMED NON-COVERED BY MY
 INSURANCE COMPANY.

 PATIENT'S SIGNATURE DATE

Financial Policy Statement

Welcome to the practice of CAPITAL VISION, (Kotecha Eye & Laser Center, PLLC) . We are pleased you have chosen this practice for your medical care. We are committed to providing you with the highest quality of services available. We ask that you carefully read and sign the following policy. We must emphasize that our relationship is with you and not your insurance carrier. As a courtesy to you, we will file your claim with your insurance company. However, **you are the sole responsible party for all charges incurred and guarantee payment thereof.** If we are contracted with your insurance company we will accept assignment. You will be responsible for your payment portion at the time of service. Failure to provide necessary referrals and/or authorizations or failure to provide accurate billing information will result in all charges for services becoming the sole responsibility of the patient/responsible party. You are expected to understand your benefits coverage and responsibilities. This includes, obtaining referrals and/or authorizations, which your insurance company requires **before** care is provided. All co-pays, co-insurance, and deductibles are due and payable at the time service is rendered. If we do not have a contractual obligation with your insurance company you are responsible for 100% of the payments at the time services are rendered. If your insurance company denies payment for your services for whatever reason you are responsible for all payments.

Please note that refractions, contact lens services, cosmetic procedures and routine exams without medical diagnosis are generally not covered by insurance companies.

Failure to pay for services may result in collection action. All collection costs incurred by this practice, including attorney's fees, will be the sole responsibility of the responsible party named herein.

In consideration of the services performed by Capital Vision (Kotecha Eye & Laser Center, PLLC) , you agree to abide by the terms of this Financial Statement.

Patient/Responsible Party Signature

Date

Patient's Authorization

I, _____, hereby authorize Capital Vision to apply for benefits on my behalf for services rendered. I request payment from Medicare, MediGap, and/or my insurance company be made directly to Capital Vision.

I certify that the information I have provided on this form is correct. I authorize the release of any necessary information, including medical information, for this or any related claim to the above named carrier(s), or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing.

Patient Signature

Date

Witness

Date