Emerald Coast Eye Institute, LLC

850-862-4001

Patient Information

Name:_____ □ M □ F

LAST NAME FIRST NAME MIDDLE

Address:_____

City:_____ State:_____ Zip:_____

Home ph.:_____ Cell ph.: _____ Work Ph:_____

Soc Sec # : _____ **Birthdate**:_____ Employer: _____

Marital Status: _____ Spouse: _____ Spouse DOB: _____

Emergency Contact Person: _____ Phone: _____

Email Address: _____

Emerald Coast Eye Institute will only use your email address to securely send your medical records and patient education material to you. Your email will not be distributed nor used for marketing purposes.

Responsible Party Information

(Please give your insurance cards to the receptionist—a copy will be made for your medical record)

Primary Insurance Co.: _____

Secondary Insurance Co.: _____

Relationship to patient: (circle one) SELF MOTHER FATHER SPOUSE OTHER

Name: _____

LAST NAME FIRST NAME MIDDLE

Address: _____

City: _____ State: _____ Zip: _____

Home/Cell ph.: _____ Email Address: _____

Cell Ph.: _____ **Birthdate**: _____ **Soc Sec #**: _____

I AUTHORIZE EMERALD COAST EYE INSTITUTE,LLC TO DISCUSS MY MEDICAL INFORMATION WITH THE FOLLOWING INDIVIDUALS:

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

Primary Medical Dr.: _____ Primary Eye Care Dr.:_____

Whom may we thank for referring you? _____

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY Date:

LIFETIME AUTHORIZATION

Medicare and/or Insurance Certificate for Payment

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or other insurance carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

I also request that this apply to any other insurance I may have.

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE.

The undersigned understands that he/she is financially responsible to Emerald Coast Eye Institute; LLC for charges involving the patient not covered by insurance and agrees to timely pay the same. All services are due and payable at the time of service.

Should Emerald Coast Eye Institute, LLC be unable to obtain payment for the balance due, we will pursue all available legal remedies and the undersigned agrees to timely pay to Emerald Coast Eye Institute, LLC all collection fees and court costs incurred in doing so.

Any parent or legal Guardian (regardless of marital status) who brings in a minor for treatment is, and hereby agrees to be, responsible for paying the minor's account in full.

Several missed appointments, habitual noncompliance or abusive behavior constitutes for dismissal from our practice.

Signed: _____ Date: _____

ACKNOWLEDGE OF RECIEPT OF NOTICE OF PRIVACY PRACTICES, OFFICE OF EMERALD COAST EYE INSTITUTE, LLC.

Signed: _____ Date: _____