NORTHWEST INDIANA EYE LASER CENTER

☐ New Patient ☐ Updated Information ☐ Updated Insurance

Today's Date:			
PATIENT INFORMATION			
Last Name	First Name & Initial		
Address 1			
Address 2	Email Address;		
City	State	Zip Code	
Home Phone	Cell Phone:		Age
Marital Status M/S/W/D	Sex: F / M	**Birthdate:**	
Patient's Social Security #			
Patient's Employer			
Employer Address			
City	State	Zip Code	
Employer's Phone	Ext		
Who Referred You Here Today?			
GUARANTOR/SPOUSE INFORMATION			
Responsible Party Last Name			
Responsible Party First Name & Initial		Relationship to Patient	
Address			
City	State	Zip Code	
Home Phone	Cell Phone		
Birthdate	**Responsible Party Social Security #**		
Employer	Employer Phone	Ext	
Employer Address	City	State	Zip Code
INSURANCE #1:			INS#1 CODE
Medicare/Medicaid/Insurance #1		Phone No.	
Address			
Policy Holders Last Name	First Name & Initial		Relationship
Certificate/ID #	Group#	Member #	
Effective Date of the Policy	**BIRTHDATE:**	**SOCIAL SECURITY:**	
INSURANCE #2:			INS#2 CODE
Medicare/Medicaid/Insurance #2		Phone No.	
Address			
Policy Holder Last Name	First Name & Initial		Relationship
Certificate#	Group#	Member#	
Effective Date of the Policy	**BIRTHDATE:**	**SOCIAL SECURITY:**	
Is your condition a result of an injury at work?	Yes No	Date of Injury:	Claim#
Is your condition a result of an auto accident?	Yes No	Date of Accient:	Claim#
Emergency Contact Person:		**Phone #:**	
INCOMPLETE OR INACCURATE COMPLETION WILL RESULT IN PAYMENT DUE FROM YOU			

YOU MUST READ AND SIGN THE OTHER SIDE OF THIS FORM

CONSENT TO TREAT: I request and give consent to Northwest Indiana Eye & Laser Ctr to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by Northwest Indiana Eye & Laser Ctr for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

INITIAL_____

RELEASE OF MEDICAL INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS:
I authorize Northwest Indiana Eye & Laser Ctr or a member of the staff to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to Northwest Indiana Eye & Laser Ctr, on my behalf.

INITIAL_____

FINANCIAL AGREEMENT: I agree to pay Northwest Indiana Eye & Laser Ctr for all services, treatments, and supplies provided to my by its Physicians, Nurses, Assistants, and Employees at the time of services or as contracted with my insurance. I assign directly to Northwest Indiana Eye & Laser Ctr the payment of my health insurance benefits, which are due for these services, treatments and supplies. I understand that no adjustment or discount will be made if my insurance company does not pay according to the managed care contract or the State of Indiana law (requires payment of an electronic claim within 30 days and a paper claim within 45 days). The Indiana law will supersede a contract agreement. I certify that the information given by me in applying for payment under Title XVIII (Medicare) and / or Title XIX (Medicaid) of the Social Security Act is true and correct. If I fail to pay for these services, I agree to pay the collection agency fees, attorney fees and court costs incurred in collecting the debt. If I am a Medicaid recipient and request and receive services for which Medicaid will not pay, I understand I must pay for those services.

PATIENT'S SIGNATURE:_____ DATE:_____

Parent / Guardian:_____ DATE:_____

E STATEMENT AUTHORIZATION:
Our practice now has the ability to send your account statement to you via email each month. This email will include a link to a secure webpage where you can view your statement and also make a payment online using a debit/credit card. We would like to offer you the opportunity to receive your account statement by email. By agreeing to receive your monthly account statement via email, you are not only helping the environment, but also gaining the convenience of making payments online at any time of the day or night. Please indicate your choice by checking the appropriate box and sign below. Please provide your current email address if you authorize the use of eStatements for your account:

☐ **YES, PLEASE SEND MY ACCOUNT STATEMENT TO MY EMAIL ADDRESS.**

My email address is _____

☐ **NO**, PLEASE CONTINUE TO SEND MY ACCOUNT STATEMENT THROUGH THE POSTAL SERVICE.

☐ Send **BOTH** eStatement AND Paper Statement. INITIAL _____

RELEASE OF PROTECTED HEALTH CARE INFORMATION VIA TELEPHONE TO ANSWERING MACHINE OR VOICE MAIL

I give my consent and authorization for the Medical, or Billing Staff of Northwest Indiana Eye & Laser Ctr to leave protected health care and billing information about me or for me on my answering machine voice mail via the telephone at the number I have listed below. I authorize text and email message for the purpose of appointments and appointment reminders. I understand I may revoke the privilege at any time by submitting my request in writing to the office. If I choose not to authorize release via the telephone, I understand, I am responsible to call the office to retrieve results of all tests and procedures.

Phone number:_____ Signature:_____

Restriction:_____