

# BōozmanHof

Regional Eye Clinic, P.A.

## Patient Information

Patient's Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient's Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M F e-mail: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

---

Spouse's Name: \_\_\_\_\_ Spouse's Social Security #: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's Work Phone: \_\_\_\_\_

---

***If patient is under the age of 18, this section must be completed.***

Parent/Guardian: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Patient/Guardian Social Security #: \_\_\_\_\_

Patient/Guardian Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## Emergency Information

*(This needs to be someone NOT living in the same house as the patient.)*

Friend, neighbor, or relative's name: \_\_\_\_\_

Phone number of above named: \_\_\_\_\_

Address of above named: \_\_\_\_\_

## Insurance Information

**In order for us to file your insurance, Please provide card(s) at check-in. Thank you.**

# BoozmanHof

Regional Eye Clinic, P.A.

## Signature on File, Assignment of Benefits, Financial Agreement

\_\_\_\_\_  
Patient's Name (Print)

\_\_\_\_\_  
Social Security Number

- 1. Medicare:** I request that payment of authorized Medicare benefits be made on my behalf to Boozman-Hof Regional Eye Clinic, P.A. (BoozmanHof) for services furnished me by BoozmanHof. 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 for 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 is indicated in item 9 of the HCFA 1500 form or elsewhere or other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. BoozmanHof accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only of the deductible, coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare Carrier.
- 2. Medigap:** I understand that if a Medigap policy or other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to BoozmanHof, if possible or otherwise to me.
- 3. Release of Information:** BoozmanHof may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation 1) which is or may be liable or under contract to BoozmanHof for reimbursement for services rendered, and 2) any health care provider for continued patient care. A copy of this authorization may be used in place of the original. 3) Family members unless otherwise indicated by patient. **I have received a copy of the Notice of Privacy Practices.**
- 4. Other insurance:** I understand that BoozmanHof maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that BoozmanHof has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by BoozmanHof if I belong to a plan that does NOT appear on the above-mentioned list.
- 5. Non-Covered services:** I understand that BoozmanHof contracts with health care service plans (i.e., HMOs, PPOs) state items and services, which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with BoozmanHof to obtain necessary health care service plan authorizations.
- 6. Financial Agreement:** I agree that in return for the services provided to the patient by BoozmanHof. I will pay any amount my insurance does not cover, including deductibles and/or co-payments at the time service is rendered, or I will make financial arrangements that day satisfactory to BoozmanHof. If my account is sent to a collection agency, I agree to pay reasonable collection expenses. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to BoozmanHof. If co-payments and/or deductibles are designated by my insurance company or health plan I agree to pay them to BoozmanHof. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.*
- 7. Authorization:** I authorize the Doctors and Staff of BoozmanHof to examine my eyes and perform any services normally associated with an eye examination.

\_\_\_\_\_  
Patient Signature or Authorized Party

\_\_\_\_\_  
Date