I acknowledge that I received a copy of the
Family Vision Corner Notice of Privacy Practices. Date: _____

Patient (or Guardian) Name: _____

Signature: _____

Refusal to sign noted by: _____

_____

PATIENT'S MEDICARE AUTHORIZATION

Patient's Name: _____

Patient's Medicare No: _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Family Vision Corner or Steven J. Trzepacz, OD, for any services furnished me by the Family Vision Corner. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to 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 on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, Family Vision Corner agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____

(Patient's Signature) (Date)

INFORMATION DESIRED FROM NEW PATIENTS

Date: **Referred By:**

Last Name:

First Name: ☐ Mr. ☐ Mrs. ☐ Miss or ☐ Ms

Address:

City: **State:** **Zip:**

Head of Household Yes ☐ No ☐ **Married ☐ Single ☐ Divorced ☐ Other ☐**

Phone: **Business Phone:**

Cell Phone: **Email:**

S.S. #: - - **Birthdate:**

Place of Employment: **Retired ☐ Full Time ☐ Part Time ☐**

Former Eye Doctor: **Date of Last Exam:**

Person (other than patient) Responsible for Payment:

Relationship to Patient:

Place of Employment:

INSURANCE INFORMATION

Name of Insured:

Address:

Birthdate: *S.S. #:*

Relationship to Patient:

Name of Employer:

Insurance Company: *Group No.:*

Insurance Company Address:

Insurance Company Telephone No.:

Do you have any additional insurance? Yes ☐ No ☐