

**PATIENT INFORMATION**

**NAME:** \_\_\_\_\_ **HOME PHONE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **CITY:** \_\_\_\_\_

**STATE:** \_\_\_\_\_ **ZIP CODE:** \_\_\_\_\_ **MARITAL STATUS:** \_\_\_\_\_

**BIRTHDATE:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **SEX:** \_\_\_\_\_ **SOC. SEC. #:** \_\_\_\_\_

**EMPLOYER:** \_\_\_\_\_ **WORK PHONE:** \_\_\_\_\_

**OCCUPATION:** \_\_\_\_\_ **RACE:** \_\_\_\_\_

**WHO RECOMMENDED US?** \_\_\_\_\_ **RELIGION:** \_\_\_\_\_

**FAMILY DOCTOR:** \_\_\_\_\_ **OPTOMETRIST:** \_\_\_\_\_

**Authorization to release:** I hereby authorize Bucci Cataract and Laser Vision Institute/Bucci Eye Surgery Center to furnish the insured's insurance company all information which said insurance company may request concerning my present claim.

**Assignment of insurance benefits:** I hereby assign Bucci Cataract and Laser Vision Institute/Bucci Eye Surgery Center all money to which I am entitled for expense relative to the services performed from time to time, but not to exceed my indebtedness to Bucci Cataract and Laser Vision Institute/Bucci Eye Surgery Center. It is understood that any money received from the insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to Bucci Cataract and Laser Vision Institute/Bucci Eye Surgery Center for charges.

**FINANCIAL ASSIGNMENT AND AGREEMENT:**

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.
2. We request that charges for visits be paid at the conclusion of each visit.(Private Pay Only)
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to be released to the Health Care Financing Administration, its agents or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A Photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

**SIGNED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_