NORTHERN WATERS OPHTHALMOLOGY SC

Patient Name:_____ Date of Birth:_____
(Legal) Last First MI (Circle one) Male / Female

Street Address:_____ Home Phone:_____
Patient's
Mailing Address:_____ Cell Phone:_____

City/State/Zip:_____ Soc Sec:_____

Employer:_____ Work Phone:_____

Responsible Person:_____ Relationship to pt:_____
(If patient is a minor)
Address:_____ Phone:_____
Resp. Person's
_____ Cell Phone:_____

Emergency Contact:_____ Relationship to pt:_____
(Not living in household)
Address:_____ Phone:_____

_____

PRIMARY INSURANCE INFORMATION **POLICY HOLDER INFORMATION**

INSURANCE COMPANY_____ Name_____

Soc Sec # _____

Insurance card necessary for filing claims Date of Birth_____

Please present cards Relationship to pt_____

Employer_____

SECONDARY INSURANCE INFORMATION **POLICY HOLDER INFORMATION**

INSURANCE COMPANY_____ Name_____

Soc Sec # _____

Insurance card necessary for filing claims Date of Birth_____

Please present cards Relationship to pt_____

Employer_____

CHART #_____ DATE_____ (OVER) >

NORTHERN WATERS OPHTHALMOLOGY SC
STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY
AND RELEASE OF INFORMATION

I acknowledge I am responsible for payment of all services Northern Waters Ophthalmology SC provides to me, including any amount not paid by third party payers. The undersigned agrees whether as patient, authorized representative, or other financially responsible party, to pay the charge for care provided to the patient by Northern Waters Ophthalmology SC.

I authorize payment directly to Northern Waters Ophthalmology SC of benefits otherwise payable to me by my insurance company(ies). If my health insurance will not allow direct payment to Northern Waters Ophthalmology SC or Northern Waters Ophthalmology SC chooses not to accept assignment of medical benefits, I agree to pay Northern Waters Ophthalmology SC amounts equal to all health insurance benefits I receive for medical care at Northern Waters Ophthalmology SC immediately upon receipt of such payments. I understand that Northern Waters Ophthalmology SC will not accept responsibility for collecting insurance or negotiating the settlement of a disputed claim.

I agree to be responsible for payment of any medical charge not paid by my insurance company(ies) or other third party.

I hereby authorize the release of pertinent medical information to all my insurance company(ies), providing coverage whether listed or not, for payment of my bill, current and future.

This authorization will remain in effect until I choose to revoke it.

If you have no insurance, please check here_____

List any insurance company you wish to exclude from this authorization (please print)

_____

Signature_____**Date**_____

Witness signature_____
If patient signs with an X

Authorized representative signature_____Date_____

Relationship to patient_____