WELCOME TO OUR OFFICE

(Please Print)

Name_____Date____/____/____

(Mr./ Dr./ Mrs./ Ms.) **First** **Middle Initial** **Last** **Suffix**

Address_____City_____ State_____ Zip_____

Date of Birth: _____/_____/_____ Soc.Sec.#_____ Sex □ M □ F

Phone: Home_____ Cell_____ Email_____

Employer_____ Occupation_____Work_____

How did you hear about our office?_____

Responsible Party

Person responsible for account_____ Soc.Sec.#_____

Relation to patient_____DOB___/___/_____ Preferred Phone_____

Address (if different from above)_____City_____State_____Zip _____

Today's payment will be: □ Cash □ Check □ Credit Card

Health/ Vision Insurance Information

Many eye problems are covered by your health insurance

Major Medical Plan_____ **Vision Plan**_____

ID #_____ ID #_____

Group #_____ Group #_____

Subscriber's Name_____ Subscriber's Name_____

All copays and individual portions of your balance are due at time of service. If you participate in any insurance plans, you are responsible for these amounts at the time of service. Granbury Eyecare,P.C. will bill your insurance directly for their portion. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize Granbury Eyecare,P.C. To release all information necessary to secure payment of benefits.
I authorize the use of this signature on all my insurance submissions.

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Patient Signature, Insured/Guardian **Date**

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf, to Granbury Eyecare, P.C. for any services furnished to me by Dr. Wadley or Dr. Zimmerman. I authorize any holder of medical information about me to release to the HCFA and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made authorizes releasing of the 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 authorized releasing of the information to the insurer agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge , and the patient is responsible only for the deductible,co-insurance,and non covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

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Beneficiary Signature, Insured/Guardian **Date**

- □ **All fees are due the day of services rendered or materials ordered.**
- □ **We accept the following forms of payment: cash, check, Mastercard, Visa, Discover & American Express**
- □ **The patient who seeks the care is responsible for payment of all fees.**
- □ **When we are a provider for a third party, any deductibles, co-payments or patient responsible fees are due when services are rendered or materials ordered.**
- □ **When we are not a provider for a third party, the patient who seeks care is responsible for payment of fees. We will provide a fee slip to submit to your third party for re-imbursement directly to you.**