PAYMENT INFORMATION

ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE UNLESS OTHER AUTHORIZED ARRANGEMENTS HAVE BEEN MADE.

PATIENT INFORMATION

First Name | Middle Initial | Last Name | (Maiden Name) | Social Security Number — —

Street Address | City/State/Zip | Mailing Address, if Different:

Home Phone Number ( ) | Cell Phone/Beeper Number ( ) | Living Will? ☐ YES ☐ NO

Age | Birthdate / / | Place of Birth | Name & Phone # of Primary Care Physician:

Sex: ☐ Male ☐ Female   Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient's Employer's Name (if unemployed, write NONE or RETIRED) | Occupation:

Patient's Employer's Address | City/State/Zip | Employer's phone Number ( )

Former Occupation, if retired:

Spouse's First Name | Last Name | Birthdate / / | Social Security Number — — | Work Phone ( )

Spouse's Employer | Street Address | City/State/Zip

MEDICARE / MEDICAID LIFETIME AUTHORIZATION

Name of Insurance Holder | Medicare Number (from Medicare card]

Medicaid Number (from Medicaid Card): | Is your coverage (please ✓):
☐STRAIGHT MEDICAID ☐MEDIPASS ☐STAYWELL ☐HEALTHEASE

If Medipass/Staywell/Healthease, who is your Primary Care Physician:

I request that payment of authorized Medicare/Medicaid benefits be made to Melbourne United Laser Vision Associates, L.L.C. on my behalf for any services furnished me by this physician or supplier. I authorize any holder of medical information about me to release to the Health Care financing Administration/Medicaid and/or its agents any information needed to determine these benefits or the benefits payable for related services. I also request that payment of MEDIGAP benefits for any and all services be made on my behalf to said physician. I authorize any holder of medical information about me to release to Melbourne United Laser Vision Associates, L.L.C. any information needed to determine these benefits or the benefits payable for related services. I understand that I am financially responsible to said physician for ANY AND ALL balances not covered by my insurance carrier.

*SIGNED: **Today's Date: / /**

OTHER INSURANCE AUTHORIZATION

Primary Insurance Co. | Name of Insurance Holder | Date of Birth | ID#

Secondary Insurance Co. | Name of Insurance Holder | Date of Birth | ID#

If your insurance is HMO/Managed Care, who is your Primary Care Physician:

I request that payment of authorized insurance benefits be made to Melbourne United Laser Vision Associates, L.L.C. on my behalf for any services furnished to me by this physician or supplier. I authorize any holder of medical information about me to release to the insurance company and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that I am financially responsible to said physician for ANY AND ALL balances not covered by my insurance carrier.

*SIGNED: **Today's Date: / /**

***If the patient is unable to sign due to mental/physical disability or in the case of a minor, authorization must be signed by a parent/legal guardian.**