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 (Nickname) Social Security Number

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

Home Phone Number Age Birthdate Pediatrician/Family Doctor's Name & Phone #:
( ) / /

Place of Birth SEX: ☐ MALE ☐ FEMALE DOES PATIENT WEAR GLASSES OR CONTACT LENSES? ☐ YES ☐ NO

Emergency Contact Relationship Address (if different) Phone Number
( )

Name of **Referring** Physician Address/City/State/Zip Phone Number
( )

PARENT INFORMATION

Mother's First Name Last Name Home Phone Work Phone
( ) ( )

Address (If different) City/State/Zip

Father's First Name Last Name Home Phone Work Phone
( ) ( )

Address (If different) City/State/Zip

MEDICARE/MEDICAID LIFETIME AUTHORIZATION

Legal Name of Insured 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 Policy Holder &Date of Birth ID#

Secondary Insurance Co. Name of Policy Holder &Date of Birth ID#

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.**