



Welcome to the Cleveland Eye Clinic

Who may we thank for telling you about our office? _____

Who is your primary care physician? _____

Full Name: _____

Address: _____ Apt # : _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Social Security # : _____

Birth date: _____ Age: _____ Male: _____ Female: _____

Emergency Contact: _____ Phone # : (____) _____

Relationship to Patient : _____

(if patient is under 18 years of age)

Guardian's Name: _____ Social Security #: _____

Insurance : (primary) _____

Insured's Name: _____

DOB: _____

Insured's Social Security Number: _____

Insurance : (Secondary) _____

Insured's Name: _____

DOB: _____

Insured's Social Security Number: _____

Please give insurance cards to receptionist to copy.

Employer : _____

Work Address : _____

Work phone # : (____) _____

Date: _____

Over Please

ASSIGNMENT OF BENEFITS

I, hereby assign all medical and/or surgical benefits, to include major benefits to which I am entitled including Medicare and other government sponsored programs, private insurance and any other health plans to Cleveland Eye Clinic.

This assignment will remain in effect until revoked by me in writing. 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 the payment of said benefits.

Signature: _____ Date: _____

FINANCIAL ARRANGEMENTS

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your help, and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by your insurance office. We accept cash, checks, Visa, Mastercard, Discover and American Express. We will be happy to help you process your insurance claim form for your reimbursement. Any request must be accompanied by a completed insurance form at each visit. In special instances, we may accept assignment of insurance benefits.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

YOU MUST REALIZE, HOWEVER, THAT:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "U.C.R.". "U.C.R." is defined as usual, customary, and reasonable fees for this region. Thus, our fees are considered usual, customary, and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies select certain services that they will not cover. We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance. If you have any questions, PLEASE do not hesitate to ask us. WE ARE HERE TO HELP YOU.

Patient's Signature: _____ Date: _____

Witness: _____