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# EYE CARE & SURGICAL CENTER OF LAUREL, P.C.

615 MAIN STREET
LAUREL, MARYLAND 20707

**PATIENT ACCOUNT NO.**

## PATIENT REGISTRATON • *Please Print Carefully*

**TAX ID NO. 52-2063352**

| PATIENT NAME: First | Middle | Last | | DATE OF BIRTH | AGE |
|---|---|---|---|---|---|
| HOME ADDRESS | Apt. No. | CITY | STATE | ZIP CODE | |
| OCCUPATION | SOCIAL SECURITY NO. | MARITAL STATUS ☐ S ☐ M ☐ D ☐ W | SEX | HOME PHONE | |
| EMPLOYER | ADDRESS | CELL PHONE | | WORK PHONE | |
| SPOUSE'S NAME (OR PARENT) | SPOUSE'S EMPLOYER (OR PARENT) | | | SPOUSE'S WORK PHONE (OR PARENT) | |
| SPOUSE'S OR PARENT'S ADDRESS | | | | | |
| NEAREST RELATIVE/FRIEND (NAME) | RELATIONSHIP | HOME PHONE | | WORK PHONE | |
| RELATIVE/FRIEND'S ADDRESS | | | | | |
| WHO REFERRED YOU? | ADDRESS | | | TELEPHONE | |

## POLICY CONCERNING PAYMENT OF MEDICAL BILLS

**WE REQUEST PAYMENT FOR SERVICES AT THE TIME OF YOUR VISIT**

For those who have insurance carriers from which we accept assignment (such as Medicare, Blue Shield, MD-IPA, Healthplus), we will submit to and accept payment from your insurance. In this case, however, please pay your co-payment, co-insurance, or deductible, at the time of your visit.

For those who have insurance with other insurance carriers, payment is the responsibility of the patient, and payment is to be made at the time service is rendered. We will provide you with completed forms that you may submit to your insurance company, so you may be reimbursed for your payment.

The undersigned agrees to promptly pay all charges when billed for medical services rendered, and the persons listed below agree and do hereby become legally responsible for any and all charges incurred for the patient above.

SIGNATURE: ______________________ DATE: ______________

## BILLING AND INSURANCE INFORMATION

| | | | | |
|---|---|---|---|---|
| SEND BILL TO | FIRST NAME | LAST NAME | RELATIONSHIP TO PATIENT | |
| | HOME ADDRESS | CITY | STATE | ZIP CODE |
| | EMPLOYER | WORK PHONE | HOME PHONE | |
| PRIMARY INSURANCE | INSURANCE COMPANY NAME | ID OR POLICY NUMBER | GROUP/CODE | |
| | INSURANCE COMPANY ADDRESS | SUBSCRIBER'S SOCIAL SECURITY | DATE EFFECTIVE | |
| | SUBSCRIBER'S NAME | HOME PHONE | RELATIONSHIP TO PATIENT | |
| | SUBSCRIBER'S ADDRESS | WORK PHONE | SUBSCRIBER'S DATE OF BIRTH | |
| SECONDARY INSURANCE | INSURANCE COMPANY NAME | ID OR POLICY NUMBER | GROUP/CODE | |
| | INSURANCE COMPANY ADDRESS | SUBSCRIBER'S SOCIAL SECURITY | DATE EFFECTIVE | |
| | SUBSCRIBER'S NAME | HOME PHONE | RELATIONSHIP TO PATIENT | |
| | SUBSCRIBER'S ADDRESS | WORK PHONE | SUBSCRIBER'S DATE OF BIRTH | |

## PATIENT'S AUTHORIZATION

I, ______________________, hereby authorize Eye Care & Surgical Center of Laurel, to apply for benefits on my behalf for covered services rendered. I request payment from BC/BS National Capital Area, Blue Shield of Maryland, Medicare and/or ______________ (other ins. co. name) be made directly to Eye Care & Surgical Center of Laurel, (or, in case of Medicare Part B benefits, to me or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or ______________ (other ins. co. name). I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above-named carrier at any time in writing.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Eye Care & Surgical Center of Laurel, for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to ______________ (Medigap Insurer) any information needed to determine these benefits payable for related services.

______________________ Signature of Subscriber or Beneficiary

______________________ E-Mail Address

______________________ Date