PLEASE PRINT AND COMPLETE FORM IN ITS ENTIRETY ACCOUNT # _____

PATIENT'S LEGAL NAME: _____DATE _____/_____/_____
First Middle Last

ADDRESS _____
Include apartment # or box # City State Zip Code

PREFERS TO BE ADDRESSED AS_____ BIRTHDATE _____/_____/_____ AGE _____

SEX: M____F____ PT SOCIAL SECURITY # _____-_____-_____ PHONE (_____) _____

CELL PHONE # (_____) _____MARITAL STATUS: _____ ETHNICITY_____ RACE_____

EMAIL ADDRESS: _____ PREFERRED LANGUAGE_____

PREFERRED METHOD OF CONTACT (circle): Home phone Work phone Cell Phone Other_____

PATIENT EMPLOYER: _____ ____ WORK PHONE (_____)_____

SPOUSE'S NAME: _____ SPOUSE'S PHONE (_____)_____

NEAREST RELATIVE _____ PHONE (_____)_____

ADDRESS_____
Not living at same address as patient

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY _____ RELATIONSHIP TO PATIENT _____

RESPONSIBLE PARTY'S EMPLOYER _____ PHONE (_____) _____

INSURANCE INFORMATION – Please complete this section on the PATIENT

PRIMARY INSURANCE INFORMATION

INSURANCE CARRIER NAME _____ ID# _____ GROUP# _____

SUBSCRIBER'S NAME _____ SUBSCRIBER'S DOB _____/_____/_____

SUBSCRIBER'S SOCIAL SECURITY # _____-_____-_____ RELATIONSHIP TO PATIENT _____

SUBSCRIBER ADDRESS _____ SUBSCRIBER PHONE (_____)_____

SECONDARY INSURANCE INFORMATION

INSURANCE CARRIER NAME _____ ID# _____ GROUP# _____

SUBSCRIBER'S NAME _____ SUBSCRIBER'S DOB ____/_____/_____

SUBSCRIBER'S SOCIAL SECURITY # _____-_____-_____ RELATIONSHIP TO PATIENT _____

SUBSCRIBER ADDRESS _____ SUBSCRIBER PHONE (_____)_____

PLEASE COMPLETE THE BACK SIDE OF THIS PAGE

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and other pay a percentage of the charge. It is the responsibility of the patient and/or responsible party to pay any deductible amount, co-insurance, or any other balance not paid for by the insurance carrier. It is also the responsibility of the patient to confirm that the provider they are seeing is a contracted provider with the patient's insurance prior to being seen by this provider. I understand I will be responsible for payment in full for services rendered if I do not furnish the required referral forms.

ALL CO-PAYMENTS, CO-INSURANCE, and NON-COVERED FEES ARE DUE THE DATE SERVICES ARE RENDERED. In the event this account is assigned to a collection agency, **the patient and/or responsible party will incur all costs of collection and attorney fees in ADDITION TO THE ORIGINAL BALANCE.**

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including private insurance, and other health plans to:

OZARK RETINA & MACULA
1230 E Kingsley St, Suite A
Springfield, MO 65804
Phone - (417) 720-4916
Fax – (417) 720-4917

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, paid or unpaid by the above said insurance. I hereby authorize Ozark Retina & Macula to release all information necessary to secure payment for services rendered.

Signed _____ ☐ PATIENT ☐ GUARDIAN ☐OTHER _____

Printed Name _____ Date _____

PLEASE PROVIDE A COPY OF THE COURT ORDER SHOWING YOU AS THE GUARDIAN FOR OUR RECORDS.

This office requires the presence of any patient's legal guardian for that patient's initial appointment. If a patient's legal guardian cannot be present for the patient's first appointment, a SIGNED & NOTARIZED proxy statement from the legal guardian, along with photo identification, MUST be received by Ozark Retina & Macula at least (1) 24-hour business day prior to the patient's initial visit.

WORKER'S COMPENSATION **CLAIM # _____**

INSURANCE COMPANY _____

ADDRESS _____

EMPLOYER AT TIME OF INJURY _____ PHONE (_____)_____

CONTACT PERSON _____ CONTACT PHONE (_____)_____

DATE OF INJURY____/____/_____ AUTHORIZATION OR CLAIM INFO_____
