OMNI EYE SERVICES

Agreement of Responsibility

I understand the professional services are rendered to the patient and the patient is responsible for the charges incurred. I understand I am financially responsible for the charges not covered by my insurance company. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I have received and reviewed the payment policy and agree to the conditions set forth in such policy. I understand I will receive a monthly statement for any balance due by me.

Initial: _____

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her medical judgment.

Initial: _____

Acknowledgement of Receipt of Privacy Practices

I acknowledge that I have received a copy of Omni Eye Specialist's P.A. Notice of Privacy Practices.

Initial: _____

Release of Information/Assignment of Benefits

I authorize the use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of an original. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered.

Name: _____ Date: _____

Signature: _____

Patient Information

Demographics

NAME (LAST / FIRST / MI)			TODAY'S DATE
STREET ADDRESS	APT#		SOCIAL SECURITY #
CITY			E-MAIL ADDRESS

STATE	ZIP CODE	BIRTH DATE	AGE	SEX
				F ☐ M ☐

HOME PHONE	WORK/ MOBILE PHONE	MARITAL STATUS
( )	( )	☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED

EMPLOYER NAME/ADDRESS	POSITION/DEPARTMENT
SPOUSE	WORK PHONE/ MOBILE PHONE ( )
EMERGENCY CONTACT / PHONE ( )	SPECIAL NEEDS: ☐ HEARING IMPAIRED ☐ TRANSLATOR ☐ WHEELCHAIR

PLEASE COMPLETE THE FOLLOWING INFORMATION

NAME OF OPTOMETRIST	PHONE ( )	HOW DID YOU HEAR ABOUT US?
LOCATION		☐ PATIENT: NAME _____ ☐ OTHER PHYSICIAN _____ ☐ INSURANCE DIRECTORY ☐ OMNI WEB SITE

STREET ADDRESS	CITY	STATE	ZIP CODE

PRIMARY CARE MEDICAL DOCTOR	PHONE ( )

STREET ADDRESS	CITY	STATE	ZIP CODE

Billing

Guarantor (Person Financially Responsible)

NAME	RELATIONSHIP TO PATIENT ☐ Self ☐ Spouse ☐ Parent ☐ Other

STREET ADDRESS	APT#	PHONE ( )
CITY	STATE	ZIP CODE

PRIMARY INSURANCE	POLICY HOLDER	POLICY ID#	SS#	INSURED'S DOB
SECONDARY INSURANCE	POLICY HOLDER	POLICY ID#	SS#	INSURED'S B/D

☐ WORKERS COMPENSATION

(over)