OPHTHALMOLOGY PARTNERS OF ROCKLAND

SOO MEE PAK, MD

DIPLOMATE OF THE AMERICAN BOARD OF OPHTHALMOLOGY

PATIENT INFORMATION

DATE: _____

LAST NAME: _____ FIRST NAME: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

☐ HOME PHONE: (_____)_____ SOC. SEC. #: _____

☐ CELL PHONE: (_____) _____

☐ WORK PHONE: (_____) _____

Please place a check next to the phone number you would like us to call should we need to contact you.

☐ OTHER PHONE: (_____) _____ MARITAL STATUS: S__ M__ W__

EMAIL ADDRESS: _____ SEX: M__ F__ DATE OF BIRTH: ___/___/___

OCCUPATION: _____ EMPLOYER: _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

EMERGENCY CONTACT PHONE: _____

If patient is a minor, please fill out the following information:

PARENT OR GUARDIAN'S NAME: _____ DOB:_____/_____/_____

PARENT/GUARDIAN'S ADDRESS: _____

SOC. SEC. # _____ PHONE: _____

INSURANCE INFORMATION

PRIMARY INS: _____ ID NO: _____ GROUP NO: _____

SUBSCRIBER: _____ RELATIONSHIP: _____

DOB: _____/_____/_____ SOC. SEC. #: _____

SECONDARY INS: _____ ID NO: _____ GROUP NO: _____

SUBSCRIBER: _____ RELATIONSHIP: _____

DOB: _____/_____/_____ SOC. SEC. #: _____

PLEASE SEE OTHER SIDE

CHIEF COMPLAINT:

_____

_____

PRIMARY CARE PHYSICIAN:

_____

I WAS REFERRED BY:

_____

NON-COVERED SERVICES

Refraction: Medicare and most managed care plans do not cover refraction, the exam to determine a prescription for eyeglasses. There is a $30 fee for this service plus any co-pays that apply.

Contact Lenses: The fitting and prescribing of contact lenses are not covered by medical insurance plans. A fee for this service will be charged on a per case basis.

INSURANCE AUTHORIZAITON, ASSIGNMENT, AND RELEASE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Brenner or Dr. Pak for any services furnished to me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

I certify that I (or my dependent) have insurance coverage as listed above and assign directly to Dr. Brenner or Dr. Pak all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of patient: _____ Date: _____