

Patient Information:

Name: _____ M F Birth date: _____
First MI Last Mo - Day - Year
Address: _____
Number Street Apt/Suite City State Zip Code
Phone: (_____) _____ (_____) _____ (_____) _____
Home Work Cell
Email: _____ SSN: _____ Employer: _____
Employer address: _____ (city) _____ (zip) _____

Spouse Name: _____ Phone #: (_____) _____
First Last
SSN: _____ Employer: _____ Employer Phone #: (_____) _____
Employer Address: _____ Spouse DOB: _____

Emergency Contact: Name: _____ Phone #: (_____) _____
First Last

Referring Doctor Information: Name: _____
First Last
Phone: (_____) _____ Fax: (_____) _____
Address: _____
Number Street Apt/Suite City State Zip Code

Family Doctor Information: Name: _____
First Last
Phone: (_____) _____ Fax: (_____) _____
Address: _____
Number Street Apt/Suite City State Zip Code

Responsible Party Information (if different from patient)

Name: _____ M F Birth date: _____
First MI Last Mo - Day - Year
Address: _____
Number Street Apt/Suite City State Zip Code
Phone: (_____) _____ (_____) _____ (_____) _____
Home Work Cell

Reports of your visit will be sent to the Referring Doctor and to your Family Doctor. If you would like additional reports sent, please indicate below. Please send copies of office visit report to:

Name: _____
First Last
Phone: (_____) _____ Fax: (_____) _____
Address: _____
Number Street Apt/Suite City State Zip Code

Insurance Information: (PLEASE BRING YOUR INSURANCE CARD(S) WITH YOU)

PRIMARY: _____ Policy # _____ Group # _____

Claims mailing address: _____ () _____
Number Street Suite City State Zip Code Phone

Policyholder Name: _____ M F Birth date: _____
First MI Last Mo - Day - Year

SSN: _____ Employer: _____ Relationship to patient: _____

SECONDARY: _____ Policy # _____ Group # _____

Claims mailing address: _____ () _____
Number Street Suite City State Zip Code Phone

Policyholder Name: _____ M F Birth date: _____
First MI Last Mo - Day - Year

SSN: _____ Employer: _____ Relationship to patient: _____

Worker's compensation or accident information (if applicable)

Date of injury: _____ Job related: Y N Auto related: Y N WC Case #: _____

Claims mailing address: _____
Number Street Suite City State Zip Code

Employer: _____ Contact Person: _____ Phone #: (_____) _____

Permission to leave a message: I give my permission for the staff of Indiana Neuro-ophthalmology & Center for Balance, LLC to leave messages concerning imaging studies, blood tests, or other medical information related to my condition (please circle all that apply):

Home answering machine Work voice mail Cell Phone voice mail email

Family member(s); name and relationship _____

Other(s); name and relationship _____

Signature: _____ Date: _____

How did you hear about our practice? _____

Insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. It is ultimately your responsibility to pay the portion of the bill not paid by your insurance company (unless otherwise restricted by law or an agreement we might have made with the insurer). We accept cash, checks, money order, Visa, MasterCard and Discover.

Assignment of benefits: I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and any other plans to Indiana Neuro-ophthalmology & Center for Balance, LLC. This assignment will remain in effect until revoked by me in writing. I hereby agree to pay Indiana Neuro-ophthalmology & Center for Balance, LLC, the charges for all medical services rendered. I shall also be responsible for any attorney fees required to collect for these services, court costs, and collection agency fees, which collection fees may account up to 35% of the charges for medical services rendered, to which may be added pre-judgment and/or post-judgment interest at the current legal rate.

Authorization of release of information: I hereby authorize Neuro-ophthalmology & Center for Balance, LLC to furnish such professional information as may be necessary to complete my insurance claim from the medical records compiled during my treatment and are hereby released from all legal liability that may arise from the release of the information requested.

I have received or reviewed or given the opportunity to review Indiana Neuro-ophthalmology & Center for Balance privacy practices (this will be available at check-in).

Signature: _____ Date: _____