Patient Name:_____ Home Phone:_____

Address:_____ City_____ State_____ Zip_____

Age:____ Date of Birth:_____ Sex:____ SSN#:_____

Employer:_____ Employer Phone:_____

Referred By:_____ Medical Doctor: _____

Emergency Contact:_____ Relationship:_____ Phone:_____

Primary Insurance:_____ ID#:_____

Subscriber's Name:_____ Group#:_____

Subscriber's Date of Birth:_____ Subscriber's SSN:_____

Subscriber's Employer:_____

Employer's Address:_____ Work Phone:_____

Secondary Insurance:_____ ID#:_____ Group#:_____

Medicare and most Blue Cross/Blue Shield plans do not cover or pay for a refraction which is determining what power or prescription is needed for glasses. For Medicare and other insurances, this is considered a separate service from the eye exam and must be billed under a separate code. If your insurance does not cover this service and you have a problem such as poor vision, blurred vision, eye strain, etc. in which a refraction is indicated, you will be expected to pay for the refraction.

If your insurance company has not paid the FULL BALANCE within 60 days, you are responsible for the TOTAL BALANCE within 15 days upon receiving the notice. If the insurance company determines the information supplied by the patient is either incorrect or incomplete the patient is responsible for the TOTAL BALANCE within 15 days upon receiving notice. Therefore, please be accurate in completing the Patient Information and the insurance information.

I undersand and agree that I am personally responsible for the charges incurred regarding my ophthalmic care in this office and shall pay for the services rendered at the time of visit unless otherwise stated by insurance contract.

Signature:_____ Date:_____

I hereby authorize Frederick Eye Institute/Robert Bruce Hodges, M.D. to furnish information to insurance carriers on my behalf for services concerning my illness and/or treatment needed to determine the benefits payable for related services. I permit a copy of the authorization to be used in place of the original.

Signature:_____ Date:_____

I authorize payment of medical benefits to Frederick Eye Institute/Robert Bruce Hodges, M.D.

Signature:_____ Date:_____

Lifetime Authorization (Medicare Only)

"I request the payment of authorized Medicare benefits be made on my behalf to Dr. Robert Bruce Hodges for any service furnished to me by that physician or supplier. 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."

Signature:_____ Date:_____