MULLIS EYE INSTITUTE
PATIENT INFORMATION RECORD

TODAYS DATE:_____ MALE ☐ FEMALE ☐ DATE OF BIRTH:_____

NAME:_____ REFERRED BY:_____

ADDRESS:_____ EMPLOYER:_____

CITY:_____STATE:_____ZIP:_____ SOCIAL SECURITY #:_____

HOME PHONE:_____ PARENT / SPOUSE:_____

WORK PHONE:_____ IN CASE OF EMERGENCY NOTIFY:

OTHER CONTACT #:_____ _____AT_____

☐ SINGLE TEMPORARY LOCAL ADDRESS AND PHONE NUMBER (if different from above):

☐ MARRIED

☐ OTHER

_____
STREET CITY STATE

_____
ZIP CODE TELEPHONE

CONSENT FOR TREATMENT, PAYMENT & OPERATIONS:

Mullis Eye Institute is committed to protecting your health information related to your medical treatment, payment for your treatment, and/or health care operations related to your treatment. Our "Privacy Notice" is posted in the waiting room for you to review. If, however, you would like a copy of our Privacy Notice, one will be provided upon your request. I understand that I am financially responsible for all charges whether or not paid by insurance.

INSURANCE: ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with the carrier(s) stated and assign directly to Mullis Eye Institute all insurance benefits, if any, otherwise payable to me for services rendered. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carries as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. 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.

Please identify the person(s) with whom your information may be shared and their relationship to you. (Please Print)

☐ Please do not share any information with anyone.

Name_____Phone_____ Relationship_____

Name_____Phone_____ Relationship_____

Name_____Phone_____ Relationship_____

PATIENT SIGNATURE:_____

(If patient is a minor, must be signed by a parent or guardian)

RELATIONSHIP:_____DATE:_____

INSURANCE

PRIMARY ☐ MEDICARE ☐ MEDICAID

INSURANCE:_____

NAME ON INSURANCE CARD:_____

RELATIONSHIP TO PATIENT:_____

SS#:_____DOB:_____

SECONDARY ☐ MEDICARE ☐ MEDICAID

INSURANCE:_____

NAME ON INSURANCE CARD:_____

RELATIONSHIP TO PATIENT:_____

SS#:_____DOB:_____

No Hidden Charges: It is our office policy that the patient and any other person responsible for payment has the right to refuse to pay, cancel payment or be reimbursed for payment for any other service, examination or treatment which is performed as a result of and within 72 hours of responding to the advertisement for any free,