EYE HEALTH PHYSICIANS OF LANCASTER

William Penn Commons • 2207 Oregon Pike, Suite 102 • Lancaster, PA 17601-40606
Phone (717) 569-0600 • FAX (717) 569-4582 • www.eyehealthphysicians.com

Patient Name _____ Date of Birth _____ Age _____
First Middle Last

Home Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Social Security Number _____

Employer/Parent's Employer _____ Occupation _____

Work Address _____ Work Phone _____

City _____ State _____ Zip Code _____

Spouse name (Parent name if minor) _____ Spouse/Parent Work Phone _____

Person(s) to notify in case of emergency (other than spouse) _____

Phone number (s) _____ Relationship _____

Referred by: _____ **Family doctor:** _____

PLEASE REMEMBER TO BRING ALL INSURANCE CARDS WITH YOU TO EVERY APPOINTMENT.

I certify that I (or my dependent) have insurance coverage as stated above. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. If an insurance referral is required, I am responsible for contacting my primary care physician at least 72 hours prior to visit. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply. Refractions are considered a "non-covered" service by Medicare and most insurance companies. If you need a Refraction you will be expected to pay the $35.00 Refraction fee at time of service.

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO EYE HEALTH PHYSICIANS OF LANCASTER FOR ANY SERVICES FURNISHED TO ME BY EYE HEALTH PHYSICIANS OF LANCASTER (DOCTORS FRISCH AND KAUFMAN). I AUTHORIZE ANY HOLDERS OF MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES OR ANY OTHER INSURANCE COMPANY THAT I HAVE COVERAGE THROUGH. THIS WOULD PERTAIN TO ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO RELATED SERVICES. I UNDERSTAND THAT CO-PAYMENTS, DEDUCTIBLES, AND ALL CHARGES NOT COVERED BY THIS AUTHORIZATION NOT PAID BY INSURANCE WILL BE THE RESPONSIBILITY OF ME, THE PATIENT.

You agree, in order for us to service your account or to collect monies you may owe, Eye Health Physicians of Lancaster and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that Eye Health Physicians of Lancaster, its employees and/or agents may contact me/us as described above.

_____ _____
Patient's signature/Parent or guardian **Date**