Livonia Ophthalmologists, P.C.

Name: _____ D.O.B.:_____

Address: _____ City, St, Zip: _____

Home Ph: _____ Cell Ph: _____

Work Ph: _____ Email: _____

Emergency Contact (name and ph) _____

Primary Care Physician(name, ph, address) _____

Pharmacy(name, number, location)_____

How did you hear about us? _____

FINANCIAL RESPONSIBILITY AND INSURANCE AUTHORIZATION

I understand that professional services rendered by Livonia Ophthalmologists, P.C. are my ultimate responsibility. Livonia Ophthalmologists, P.C. will assist in facilitating reimbursement from third party carriers by verifying coverage when necessary. However, by verifying coverage, the extent of that coverage is not a guarantee for payment of the rendered treatment.

Co-payments that I am required to pay must be paid on the day I am seen.

Annual deductible: If I have not met my annual deductible I understand that I will be asked to pay at the time of service. If, at a later time, my insurance rejects any part of my claim or charges an additional deductible amount, co-pay or co-insurance, I accept responsibility for these charges.

Services not covered or not paid are my complete responsibility and I will pay Livonia Ophthalmologists, P.C. in a timely and mutually acceptable time frame.

Self-pay: If Livonia Ophthalmologists, P.C. does not participate with my insurance or if I do not have any insurance or my insurance Is not active, I understand that I am responsible for any and all charges incurred and that payment is requested at the time of service.

Refraction is the vision portion of a comprehensive exam that most insurance companies do not cover. I understand that I will be responsible for this portion of the exam.

Referrals: If I am enrolled in an insurance plan which requires a referral from my Primary Care Physician, I understand that I must have a referral in order to be seen by the physician. If I arrive without a referral I will pay for the visit at the time of service or reschedule the visit.

Digital Recordings: Recordings of any kind by handheld devices are prohibited on the premises in order to protect the privacy of other patients and staff in compliance with federal and state privacy laws.

Authorization for treatment and release of information: I hereby give permission to all Livonia Ophthalmologists, P.C. Physicians and Assistants as may participate with my treatment to examine and treat me medically or surgically. I authorize Livonia Ophthalmologists, P.C. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependent. I further authorize Livonia Ophthalmologists, P.C. to release any pertinent medical information about me (or my dependent) to any referring physician and/or my employer in the event of a work related injury. I permit a copy of this authorization to be used in place of the original.

I have read and understand my obligations and have received a copy of this form.

Signature _____ Date Signed _____

If patient is a minor, parent or legal guardian must sign