

**WELCOME TO THE OFFICE OF AFFILIATED EYE SURGEONS
SIDNEY K. SIMONIAN, D.O.**

PLEASE COMPLETE ALL AREAS SO WE MAY SERVE YOU BETTER

MISS. MRS. MS. MR.

First Name: _____ Initial _____ Last Name: _____

Date of Birth: _____ Sex M / F Social Security# _____

Daytime Phone#(____) _____ 2ND PH#(____) _____ SENT BY: Doctor / Patient / Insurance _____

Address _____ City: _____

State: _____ Zip Code _____ Email _____

EMERGENCY CONTACT Name _____ Phone# (____) _____

INSURANCE INFORMATION In order to receive payment, **WE REQUIRE INFORMATION ABOUT THE PERSON WHO CARRIES YOUR INSURANCE POLICIES.** If this is not yourself, please provide the SUBSCRIBER'S NAME, DATE OF BIRTH, SOCIAL SECURITY# AND RELATIONSHIP to you. **WE ARE UNABLE BILL YOUR INSURANCE WITHOUT THIS INFORMATION.**

MEDICAL INSURANCE _____ Subscriber _____ DOB _____ SS# _____ Relationship _____

2ND MEDICAL INS. _____ Subscriber _____ DOB _____ SS# _____ Relationship _____

VISION INSURANCE _____ Subscriber _____ DOB _____ SS# _____ Relationship _____

2ND VISION INS. _____ Subscriber _____ DOB _____ SS# _____ Relationship _____

AUTO OR WORKERS COMP INJURIES ONLY CARRIER NAME _____ Claim # _____

CONTACT PERSON _____ Phone# _____

ALL PATIENTS PLEASE SIGN:

MEDICAL VISITS are billed to your medical insurance. This is **NOT A GUARANTEE OF COVERAGE. MEDICAL INSURANCES PAY FOR MEDICAL TREATMENT, NOT FOR ROUTINE EYEGLOSS EXAMINATIONS.**

EYEGLOSS EXAMINATIONS are billed separately from your office visit and may be payable by your **VISION INSURANCE.** Please inform the receptionist if you have vision coverage. **If an eyegloss exam is done and you do not have coverage you will be responsible for \$35.00.** Contact lens fitting is a separate fee. **Both services are payable on the day of service.**

It is understood that you accept responsibility for any **AMOUNTS NOT COVERED** by your insurance including **COPAYS AND DEDUCTIBLES.** **COPAYS** are **DUE ON THE DAY** of your visit. A **STATEMENT FEE** will be added if the office has to send a bill to you. **BOUNCED CHECKS** will also add a separate fee to your bill.

Affiliated Eye Surgeons will **BILL YOUR INSURANCE** based on the **REASON FOR YOUR VISIT AND YOUR DIAGNOSIS.**

YOUR SIGNATURE BELOW ALLOWS US TO BILL YOUR INSURANCE COMPANY on your behalf and **VERIFIES THAT YOU UNDERSTAND OUR BILLING PROCEDURES.** A copy of the **OFFICE FINANCIAL POLICIES** will be provided to you.

SIGNATURE _____ DATE: _____

MEDICARE PATIENTS PLEASE SIGN: I HEREBY AUTHORIZE MEDICARE TO FURNISH THE ABOVE DOCTOR ANY INFORMATION REGARDING MY MEDICARE CLAIMS UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT

SIGNATURE _____ DATE: _____

HIPPA GOVERNMENT MANDATED HEALTH INFORMATION PRIVACY ACT

To protect your privacy, we will directly speak to you about your treatment. If you would like us to provide treatment information to your family or caregivers please consent and list their names below and relationship to you. This does not include doctors / hospitals.

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____