



Advanced eye care & Glaucoma Center  
Your Vision Becomes Our Vision.

**REFERRED BY:** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_

***PATIENT INFORMATION:***

1. NAME: First: \_\_\_\_\_ MI: \_\_\_\_ Last: \_\_\_\_\_

2. Birthdates (mm/dd/yy): \_\_\_\_\_ Sex: M /F

3. Address: City/ St/ Zip: \_\_\_\_\_

4. Tel(Home) \_\_\_\_\_ Tel (Cell) \_\_\_\_\_

5. Email \_\_\_\_\_

6. Fax \_\_\_\_\_

7. Social Security number: \_\_\_\_\_

***EMERGENCY CONTACT:***

1. NAME: First: \_\_\_\_\_ Last: \_\_\_\_\_

Phone (Cell): \_\_\_\_\_ Relationship \_\_\_\_\_

Address: \_\_\_\_\_

***INSURANCE COMPANY INFORMATION***

Primary Insurance Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Vision Service Plans Name \_\_\_\_\_

Policy Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

I, acknowledge that I have reviewed the Notice of Privacy Practices and Payment Policies and Insurance Plan Benefits that describes how **AEC&GC** uses and discloses my protected health information and payment policies. I am aware that a printed copy is available at the reception and on the Website at [www.drghiasimd.com](http://www.drghiasimd.com) or upon request.

**CONFIDENTIALITY AND BENEFITS, ASSIGNMENT AND RELEASE:**

I, the undersign, certify that, I (or my dependent) have insurance coverage and assign directly to **AEC&GC** all insurance benefit to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by insurance. I understand that my records are confidential and my signature authorizes the doctor to release all information necessary for the purpose of healthcare, insurance operation and to secure the payment of benefits. I authorize the use of this signature on all insurance submission.

**MEDICARE AUTHORIZATION:**

I request that payment of authorized Medicare benefits be made to me or on my behalf to **AEC&GC** for any services furnished to me by their doctor. I authorize any holder of medical information about me to be released to Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer of agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is only responsible for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of patient/Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_