

Welcome to Our Office

Please take a moment to fill this patient information sheet. It will assist us in filing your insurance correctly for you. All information is kept completely confidential. Thank you.

Circle one: Dr. Mr. Mrs. Ms. Miss **Are you?** Married Single Widowed

Last Name: _____ First Name: _____

SS# _____ DOB _____ Age: _____ Male Female

Address: _____ City: _____ ST: _____ Zip: _____

Home Ph# _____ Work Ph# _____ ext _____

E – Mail Address: _____ @ _____

Employer: _____ Occupation: _____

GUARANTOR (if not the patient) _____ Relationship: _____

Billing Address: _____ City/ST/Zip: _____

Home PH# _____ Work PH# _____

Emergency Contact: _____ Daytime PH # _____

If you would like for us to bill your insurance for you, please fill out the following information.

Primary Insurance Carrier: _____ Policy : _____

Policyholder's Name: _____ Group#: _____

Policyholder's SS#: _____ DOB: _____

Policyholder's Employer: _____ Relationship to patient: _____

Secondary Insurance Carrier: _____ Policy: _____

Policyholder's Name: _____ Group # _____

Policyholder's SS#: _____ DOB: _____

Policyholder's Employer: _____ Relationship to patient: _____

Please read carefully and sign the following agreement.

For our patients with Insurance:

I authorize the release of any medical or other information necessary to process my claim to the insurance carriers listed above. I understand that it is my responsibility to know my insurance coverage and to obtain any referrals or authorizations necessary. I also understand that any balance not paid by the insurance company after 60 days is my responsibility. I authorize the payment of medical benefits to Dr. Gene Terrezza by my insurance carrier.

Lifetime signature: _____

For our patients with Medicare:

Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862 (a) (1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. If there is no medical reason for your visit, or no medical diagnosis then Medicare will likely deny your claim. If Medicare denies payment, I agree to be personally and fully responsible for payment. I authorize the release of any medical or other information necessary to process my claim to the insurance carriers listed above. I understand that it is my responsibility to know my insurance coverage and to obtain any referrals or authorizations necessary. I also understand that any balance not paid by the insurance company after 60 days is my responsibility. I authorize the payment of medical benefits to Dr. Gene Terrezza by my insurance carrier.

Lifetime signature: _____

I have received a copy of Privacy Practices from Dr. Gene Terrezza, O.D., & Associates, P.A.

Signature _____