PITTBURGH OCULOPLASTIC ASSOCIATES, Ltd.

Acct # _____

PATIENT INFORMATION

Patient Name: _____ Marital Status: _____
Social Security Number: _____ Driver's License No: _____
Employer: _____ Employer's Phone No: _____
Employer's Address: _____ Retired? _____

Person to Contact in Case of Emergency: _____ Phone: ( ) _____
Address: _____Relation to You: _____

GUARANTOR INFORMATION (Person responsible for Payment of Account)

Guarantor Name: _____ Guarantor's Phone: ( )_____
Address: _____ Guarantor's Employer: _____
_____ Guarantor's Social Security #: _____
Guarantor's Date of Birth: _____

INSURANCE INFORMATION

Primary
Name of Insurance Company: _____
Name of Policy Holder: _____ Relationship to Patient: _____
ID # _____ Group # _____ Date of Birth _____
Employer: _____

Secondary
Name of Insurance Company: _____
Name of Policy Holder: _____ Relationship to Patient: _____
ID # _____ Group # _____ Date of Birth _____
Employer: _____

Other
Medical Assistance Program Recipient ID# _____ Card Issue # _____
Worker's Compensation/Auto Accident/Trauma (Circle and Complete on Reverse Side)

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, private insurance and any other health plans to Pittsburgh Oculoplastic Associates. Ltd. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize release of any information needed to determine these benefits payable for related services. I am financially responsible for the deductible co-insurance, and non-covered services. Co-payments and non-covered services are to be paid at the time services are rendered. I understand that I am to forward any payment that I may receive from my insurance carrier for services rendered. I have read and understand the payment policy of Pittsburgh Oculoplastic Associates.

Signature of Patient/Guarantor: _____ Date: _____

Signed by Policy Holder (If other than patient) _____

ACCIDENT CLAIM INFORMATION

Date of Accident: _____

Type of Accident (Circle One): Worker's Compensation Automobile Other

Claim Number: _____

Insured Party: _____

Name of Insurance Company: _____

Claim Address: _____

_____

Phone: ( ) _____

Name of Claim Representative: _____

Policy Limit Amount: _____