GRIFFIN EYE CLINIC
EYE PHYSICIANS & SURGEONS

LEIV M. TAKLE, M.D. * THOMAS S. ROWE, M.D. * LEIV M. TAKLE, JR. M.D.

PATIENT NAME:_____**D.O.B.**_____ **AGE**_____
Sex: Male____**Female**____**Single**___**Married**___**Widowed**____**Divorced**_____
Home Phone_____**Cell Phone**_____
Address_____**City**_____**State**____**Zip**_____
Employer_____**Occupation**_____
Work Address_____**Work Phone**_____
Social Security #_____**E-mail**_____

Person Responsible for Payment (if different from patient)_____
D.O.B._____**Home Phone**_____**Cell Phone**_____
Employer_____**Work Phone**_____
Work Address_____**City**_____**State**____**Zip**_____
Social Security #_____

Another Contact Name & Number (Should we have to reach you and you are not Available at the numbers listed above)
Name_____**Phone #**_____

INSURANCE- If your insurance requires a referral, you are responsible for obtaining that referral **before** your office visit. We reserve the right to reschedule you appointment if you do have a required referral.

PATIENTS ARE REQUIRED TO HAVE THEIR INSURANCE CARDS AT THE TIME OF SERVICE.

For additional information pertaining to our insurance policies, please see attached forms.

BILLING – We will bill you monthly and for the first 60 days you will receive regular bills notifying you of your financial responsibility. Any balance that is ninety (90) days old from the last payment received on your account, you will be sent a notice or you will be contacted by telephone, that your account is considered past due. One hundred twenty (120) days from the last payment, your account will be reviewed and you will be notified that your account will be considered for collection agency. If you have not responded within 30 days of that final notice or telephone contact, we will be forced to turn your account over to our collection agency. Should you have a check that is returned to us for non-sufficient funds or account closed, a fee of $15.00 will be added to your outstanding balance and we will ask that you pay in cash or credit card.

CONTACT LENSES – Pricing for contact lenses vary depending on if you are a new fit or need a refitting in a different type of contact. Our contact lens fees depend on the type of contacts that you need or want. Please let us know if you want an update on your contacts at the time of your eye exam. Please note: **Glasses and contact lens prescriptions are not the same.**

ROUTINE EYE EXAM: ***The routine portion of the eye exam, refraction (the actual test for glasses) is usually not covered by most insurance companies and is billed separately.***

MEDICARE

I request that payment of authorized Medicare benefits be made on my behalf to Leiv M. Takle, M.D., Thomas S. Rowe, M.D., or Leiv M. Takle, Jr., M.D. for any services furnished by the listed provider / supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent, any information needed to determine these benefits or the benefits payable to the related services.
I understand my signature (signed below) 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 the releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient name_____ **Date**_____

Patient signature_____

OTHER INSURANCE
Patient's or Authorized Person's Signature – I authorized the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim.

This assignment 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 said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed_____ **Date**_____