specs sunflower pediatric eye care & strabismus LLC

N. Marie Koederitz, MD

PATIENT INFORMATION

FULL NAME_____

SEX: MALE FEMALE DATE OF BIRTH_____

IF CHILD: MOM'S NAME _____ DAD'S NAME _____

ADDRESS_____CITY_____ST_____ZIP_____

CELL PHONE_____ ALTERNATE PHONE_____

EMAIL ADDRESS_____ Initial if OK to Text _____ email _____

PREFERRED LANGUAGE_____RACE_____ETHNICITY_____

REFERRING PHYSICIAN_____CITY: _____

PRIMARY CARE PHYSICIAN_____CITY: _____

PHARMACY _____ ADDRESS _____

IF THE PATIENT IS A DEPENDENT, PLEASE PROVIDE THE FOLLOWING INFORMATION:

RESPONSIBLE PARTY NAME_____RELATIONSHIP_____

DATE OF BIRTH_____ SSN _____ PHONE_____

ADDRESS_____CITY_____ST_____ZIP_____

EMERGENCY CONTACT PERSON IF RESPONSIBLE PARTY CANNOT BE REACHED:

NAME: _____ PHONE: _____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY_____ ID #_____

POLICY HOLDER_____ RELATIONSHIP_____

POLICY HOLDER DATE OF BIRTH_____GROUP #_____

SECONDARY INSURANCE COMPANY: _____

WE DO NOT CONTRACT WITH ANY VISION PLANS

PATIENT NAME_____**DOB**_____

INSURANCE PAYMENT AUTHORIZATION

I authorize SPECS LLC and its representatives to file my primary and secondary insurance and receive payments for services rendered. **I understand that I am responsible for the deductible, coinsurance, and non-covered services. Coinsurance and deductible amounts are based upon charge determination of my insurance carrier. I understand that I am responsible for any balance that is not paid or covered by my insurance.**

PATIENT/GUARDIAN SIGNATURE_____DATE_____

PATIENT PAYMENT AUTHORIZATION

I understand that if I do not have insurance or that SPECS LLC is not a provider with my insurance, than I will be responsible for any balance that is not covered.

PATIENT/GUARDIAN SIGNATURE_____DATE_____

MEDICARE LIFETIME AUTHORIZATION

I request the payment of authorized Medicare benefits be made on my behalf to SPECS, LLC for services furnished to me. I authorize any holder of my medical information to release to HCFA and its agents any information needed to determine benefits or benefits payable for related services.

I understand that I am responsible for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon charge determination of the Medicare carrier.

BENEFICIARY OR AUTHORIZED SIGNATURE_____DATE_____

I RECEIVED THE NOTICE OF PRIVACY PRACTICES FOR *SPECS, LLC* .

I RECEIVED AND AGREE TO THE *SPECS, LLC* OFFICE AND FINANCIAL POLICY.

PATIENT/GUARDIAN SIGNATURE_____DATE_____