PATIENT INFORMATION RECORD

Name_____Date of Birth___/___/_____
Last, First, Middle initial
Age_____ Sex M F Social Security Number_____/____/_____

Mailing Address_____

City_____ State_____ Zip_____ Home Phone#_____

Parent or Guardian(minor)_____PH#_____

Email address_____

Emergency Contact_____PH#_____

INSURANCE INFORMATION

Primary Insurance Carrier_____

Member's name_____DOB___/___/_____

ID#_____ Group#_____ Relation to member_____

Secondary Insurance Carrier_____

Member's name_____DOB___/___/_____

ID#_____Group#_____ Relation to member_____

Agreements: Please initial and sign below

_____I authorize the release of any medical or other information necessary to process my insurance claims. I authorize payment of my government and/or private insurance benefits directly to Dr. Kosterman, OD.

_____I understand I am responsible for the payment of any copays and deductibles per my insurance policy. Payment is expected at the time of service unless other arrangements have been made in advance.

_____If I do not pay my balance due within 60 days of notification, my account will be turned over to a collection agency, and I will be responsible for all collection agency fees in addition to my outstanding balance with Dr. Kosterman.

_____I understand that any additional testing required may be billed to my insurance as a *medical* procedure (ie. Retinal Photography, Visual Field Exams) therefore may be subject to my medical deductible.

_____I have been given the opportunity to read my HIPAA privacy rights.

Signed_____Date___/___/_____