PATIENT INFORMATION

Last Name:	First Name:		Initial:
Home Address:	City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	
Social Security Number:	DOB:	Age:	M / F

The above information is required by insurance carriers and must be completed in order to submit a claim.

Email Address:

Occupation:

Financial responsibility for this exam: Self pay VSP EYEMED MES ROTC Production Medicare

Other Insurance:	Secondary:
Primary care provider:	Phone:

How did you find our office?

Signature on File

Medicare:

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Jonathan Gording, Optometry, P.C. for services rendered by the office. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests payment to be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of HCFA form 1500, my signature authorizes releasing of the information to the insurer of agency shown.

Dr. Jonathan Gording, Optometry, P.C. accepts the charge determination of Medicare carrier Noridian as full charge and the patient is responsible only for deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon charge determination of the Medicare Carrier.

Signature Date

Other Insurance:

I hereby authorize payment of medical and eye benefits to Dr. Jonathan Gording, Optometry, P.C. I understand that I am financially responsible for any charges whether or not paid by said insurance. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Dr. Jonathan Gording, Optometry, P.C. I authorize Dr. Jonathan Gording, Optometry, P.C. to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

Signature Date

Private/No Insurance:

I certify that above information is correct. I understand that I am responsible for payment to Dr, Jonathan Gording, Optometry, P.C. at the time of services and/or materials rendered.

Signature Date