Bradley A. Bertram, M.D. FACS
Bruce A. Brown, M.D.
Herbert P. Fechter, M.D.
Beau Gardner, M.D.
Ryan T. Smith, M.D.

EYE GUYS

www.eyeguys.com

Elizabeth A. Martin, O.D.
Doug W. Ellenberger, O.D.
Robert R. Morgan, O.D.
Christopher R. Cutright, O.D.
James Lockwood, M.D.

PATIENT INFORMATION (PLEASE PRINT)				
Name (Last, First, MI)		Gender	Mr. Mrs. Ms. Dr.	Date of Birth
Mailing Address-Street	City	State	Zip	Race
Home Phone	Cell Phone		Preferred Phone (Circle One) Cell Home	
E-mail address				
Social Security Number	Marital Status (Circle One) S M W D	Primary Language	Ethnicity: ☐ Not Hispanic / Latino ☐ Hispanic / Latino ☐ Unknown	
Emergency Contact Name/ Relationship		Emergency Contact Numbers		

RESPONSIBLE PARTY INFORMATION IF OTHER THAN SELF (PLEASE PRINT)			
Name (Last, First, MI)			Mr. Mrs. Ms. Dr.
Date of Birth	Social Security Number	Relationship	
Mailing Address-Street	City	State	Zip

ACKNOWLEDGEMENT, AUTHORIZATION, AND CONSENT

Authorization / Consent for Examination and Treatment

I hereby agree and give consent to the treating physician and employees of this office and any affiliations; Eye Physicians and Surgeons of Augusta; Eye Surgery Center of Augusta; Eye Guys Specs Vision Center; hereafter called Eye Guys; and other associates to diagnose and treat the patient named on this form. I consent to any and all treatment including, but not limited to, physical examinations and other procedures related to the routine diagnosis and treatment of the patient as necessary and appropriate by the treating physician, his/her partners, associates, and consultants. My presence at each future appointment implies and confirms my ongoing consent for treatment. I understand no guarantee or assurance has been made as to the results that may be obtained.

Assignment of Benefits

I hereby assign and authorize my insurance carrier or other benefits plan including Medicare, other government sponsored insurances and benefits of which I may be covered and/or all commercial payers to make payments on my behalf directly to Eye Guys for services rendered. I authorize any holder of medical information about me to release to Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. I authorize Eye Guys to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If other health insurance is indicated in item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Eye Guys accepts the charge determination of the Medicare carrier as the full charge. I am responsible for the deductible, coinsurance and noncovered services.

Financial Responsibility

I understand that payment is due at the time of service. I understand that all charges for services rendered at Eye Guys are ultimately the responsibility of the patient. Eye Guys will file claims with most insurance and benefit plans, however, once the claim has been processed, all co-insurance, any remaining copay, deductible amounts as well as fees for any service rendered, but not covered by my insurance policy are due upon receipt of the billing statement. I will receive a statement from Eye Guys for such fees not paid at the time of service. I further agree that, if permissible by law, I will reimburse Eye Guys for all costs, expenses, attorney fees that may be incurred in attempts to collect those charges.

Authorization to Release Information:

I hereby authorize the release of any medical or other information necessary to process claims on my behalf. I agree to be fully responsible for all lawful debts incurred by myself or my child/children for services rendered.

I certify that I have read and understand the above statements, that all of my questions have been answered to my satisfaction, and that I agree with each statement above.

_____ _____ _____

Patient/ Responsible Party Signature | Relationship to Patient | Date