EYE PHYSICIANS, P.C.
Columbus, Nebraska

PATIENT INFORMATION SHEET

Please Print Clearly

Patient Name:_____ Sex: M_____F _____
Last First MI

Mailing Address: _____

City, State, Zip: _____

Home Phone: _____ Age _____ Student: Yes _____ No _____

Birth Date: _____ Social Security # _____ /_____ /_____ Marital Status S M W D

Patient Employer:_____ Work Phone:_____

Parent/Spouse Name:_____ Spouse Social Security #_____/ _____/_____

Parent Spouse Employer: _____ Work Phone:_____

Spouse Birth Date: _____

List any children living at home and their age:_____

Family Doctor: _____

Have you ever claimed bankruptcy? If so, when _____

Person to contact in case of Emergency
(SOMEONE NOT IN YOUR HOME) _____ Phone:_____

Email:_____

SIGNATURE:_____ TODAY'S DATE:_____

(OVER)

12/05/05

EYE PHYSICIANS, P.C.
Columbus, Nebraska

Signature on File, Assignment of Benefits, Financial Agreement

MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Eye Physicians, P.C. for services furnished me by Eye Physicians, P.C. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature 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 HFCA 1500 form or elsewhere on other approved claims forms, my signature authorizes releasing the information to the insurer or agency shown. Eye Physicians P.C. accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HFCA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on by behalf or Eye Physicians P.C. , if possible or otherwise to me.

OTHER INSURANCE: I understand that Eye Physicians P.C. maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that Eye Physicians P.C. has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Eye Physicians, P.C if I belong to a plan that does not appear on the above mentioned list.

NON-COVERED SERVICES: I understand that Eye Physicians P.C.'s contracts with health care service plans relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Eye Physicians P.C. to obtain necessary health care service plan authorizations.

FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Eye Physicians P.C. , I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Eye Physicians P.C. for payment. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Eye Physicians P.C. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Eye Physicians P.C. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

_____ _____

Beneficiary Signature or Authorized Representative Date

12/05/05