FINANCIAL CONSENT

DEMOGRAPHICS

Last Name	First Name	Middle Name	DOB	Age	Gender
Marital Status	SSN	Driver License	Occupation	Race	Religion
Language	Address 1	Address 2	City	State	Zip
Country	Phone #	Mobile	Work Phone	Performing	Anesthesiologist

Patient

Home Phone Permissions: May we leave a message with medical information?
◉ Yes ◉ No

Moble Phone Permissions: May we leave a message with medical information?
◉ Yes ◉ No

Patient Relationship to Responsible Party:	Employer:	Occupation:

Primary Care Physician:	Primary Care Physician Phone Number:

RESPONSIBLE PARTY

Responsible Party - First Name	Responsible Party - Last Name	Responsible Party - Middle Name	Responsible Party - DOB	Responsible Party - SSN	Responsible Party - Address 1
Responsible Party - Address 2	Responsible Party - City	Responsible Party - State	Responsible Party - Zip	Employer:	Occupation:

PRIMARY INSURANCE

Primary Insurance	Primary Group #	Primary Policy #	Primary Subscriber Last Name	Primary Subscriber First Name	Primary Subscriber Middle Name
Primary Subscriber DOB	Primary Subscriber Gender	Primary Subscriber Relationship to Patient	Primary Subscriber SSN	Primary Subscriber Employer	

SECONDARY INSURANCE

Secondary Insurance	Secondary Group #	Secondary Policy #	Secondary Subscriber Last Name	Secondary Subscriber First Name	Secondary Subscriber Middle Name
Secondary Subscriber DOB	Secondary Subscriber Gender	Secondary Subscriber Relationship to	Secondary Subscriber SSN	Secondary Subscriber Employer	

FINANCIAL CONSENT

CONSENT

1.In consideration of the services to be rendered to me, I HEREBY INDIVIDUALLY OBLIGATE MYSELF TO PAY THE ACCOUNT IN ACCORDANCE WITH THE REGULAR RATES AND TERMS. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. Should my account become delinquent and be referred to an attorney or licensed collection agency for collection, I shall pay the outstanding balance owed along with reasonable attorney fees and collection expenses. All delinquent accounts (those not paid within 60 days from the date of service) shall bear interest at the legal rate.

2. I further authorize the release of any information pertinent to my case to any insurance company adjuster or attorney involved in this case.

3. I authorize the physician to initiate a complaint to the insurance commissioner for any reason on my behalf.

4. I hereby authorize direct payment of any insurance benefits otherwise payable to me for this admission at a rate not to exceed the regular charges. It is agreed that payment pursuant to this authorization by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. I understand that I am financially responsible for charges not covered by this agreement.

5. I request that payment of authorized Medicare benefits be made either to me or on my behalf to this center. I authorize any holder of medical information about me to release to the Healthcare Financing Administration, and its agents, any information needed to determine these benefits or the benefits payable for related services.

6.I certify that I am the patient or am duly authorized by the patient as the patients representative to execute this document and accept its terms.

7.I understand that, as a courtesy, ADVANCED VISION SURGERY CENTERwill file my primary insurance claim. After 60 days, should my insurance fail to cover my treatment, I am fully responsible for the balance unpaid.

8.I authorize the release of information to cover my claim.

9. I hereby authorize ADVANCED VISION SURGERY CENTER to share my personal and medical information with the EYE CARE CENTER OF NORTHERN COLORADO for the purposes of billing, collections and continuity of care.