

Welcome to the office of
Daniel R. Obermark, O.D.

Thank you for choosing our practice for your eye care needs.

Please help us help you by completing this form.
If you have any questions, concerns, or don't understand an entry, please ask. We are happy to help.

Demographics—Patient Information

Today's Date _____ **Please present your insurance cards to the receptionist**

Patient: _____
Address _____
City _____ State _____ Zip _____
e-mail _____
Home Phone _____ Cell Phone _____ Work Phone _____
Patient's Date of Birth _____ Patient's Social Security # _____
Occupation _____ If student, current grade _____
Employer _____ School or University _____
Emergency Contact Name _____ Phone _____

Other family members.

If they have been a patient of ours, please put a check in the box by their name.

Spouse's Name _____
Children's Names _____ Ages _____

Guarantor—Person Responsible for Bill

Person responsible for bill Self Spouse Parent Workers Compensation Other _____
Guarantor's Name _____
Address _____
City _____ State _____ Zip _____
Guarantor's Phone _____ Guarantor's Social Security # _____

Referral Information

Whom may we thank for telling you about our practice? Yellow Page ad Newspaper ad Sign Radio ad TV ad
Person's Name _____ Doctor's or Optician's Name _____ Other _____

Insurance / HIPAA Authorization

Agreement of Responsibility

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductibles and co-insurance may be collected at the time of service. I understand that I am financially responsible for charges not covered by my insurance company.

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her medical judgment.

Release of Information/Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me.

Medicare Authorization

I request payment of authorized Medicare benefits be made on my behalf to Dr Obermark, Optometry, PC for any services furnished me by that physician. I authorize the holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or the benefits payable to related services. I understand that 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 HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Medigap Authorization

A Medigap or Medicare Supplemental policy is a health insurance policy or other health benefit plan, offered by a private company, to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered by an employer to employees or former employees, as well as a policy or plan offered by a labor organization to members or former members. This Agreement is in effect until revoked in writing by the patient.

I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
I further authorize and request that insurance payments be made directly to Dr. Daniel R. Obermark, Optometry, PC.
I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.
I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Date: _____ Signature: _____

FEES DUE UPON SERVICES RENDERED.

Please check your preferred method of payment: Cash Check Credit Card

Please continue medical history on back

Over Please 

