ATLANTIC EYE

300 S HIGHWAY 35, SUITE 300. EATONTOWN, NJ 07724 | 732.222.7373
1963 NJ-34 BUILDING B, SUITE 101. WALL TOWNSHIP, NJ 07719 | 732.223.6555
100 COMMONS WAY # 230, HOLMDEL, NJ 07733 | 732.796.7140
180 WHITE ROAD, SUITE 202. LITTLE SILVER, NJ 07739 | 732.219.9220

PATIENT INFORMATION

Patient Name: _____ **Date:** _____

Street Address: _____ **Male** ■ **Female** ■

City, State, Zip: _____

Date of Birth: _____ /_____ /_____ **Age:** _____ **Telephone (Home):** _____

Social Security #: _____ /_____ /_____ **Telephone (Work):** _____

Email: _____ **Telephone (Cell):** _____

INSURANCE INFORMATION – PLEASE PRESENT ALL INSURANCE CARDS

Insurance Company: _____ **ID:** _____

Subscriber: _____ **S.S#:** _____ / _____ / _____ **DOB:** _____

Relation to Patient: _____

EMERGENCY CONTACT

Name: _____ **Telephone:** _____ / _____ / _____

PAYMENT OF PROFESSIONAL FEES

Full payment /Co-payments/ Non-Covered Costs are due at the time of service.

Medical /Vision Insurance-You acknowledge that it is YOUR RESPONSIBILITY to inform Atlantic Eye of your current insurance plan(s) prior to your visit. Please be aware if you have both Medical & Vision Insurance we will submit to the appropriate insurance based on Doctors findings at the time of your exam. You acknowledge that any insurance information given after your visit may result in the visit being denied by your insurance making the total bill the patients responsibility.

Medicare lifetime signature on file: "I request that payment of authorized Medicare benefits be made on my behalf to Atlantic Eye Physicians for any services furnished me by the physicians or supplier."

Referral-If your insurance company requires a referral prior to service, you acknowledge that it is YOUR RESPONSIBILITY to obtain and furnish Atlantic Eye with a current referral. We cannot provide the service until YOU have secured the referral from your Primary Care Physician.

Refraction, Contact Lenses Service Fees-Refraction & Contact Lense Services are typically a non covered service by Medicare or most medical insurance plans. Our office fee for refraction is $55 and Contact Lenses service fees range from $50+ depending on the service(Contact Lenses fees will be quoted prior to service) These fees are due at the time of service in addition to any co-payment your plan requires. Should your insurance pay us for these services, we will reimburse you accordingly.

PATIENT'S STATEMENT OF ACCEPTANCE AND UNDERSTANDING

I authorize the release by Atlantic Eye Physicians of my medical information that is necessary to evaluate and pay my medical insurance claims.

By signing below, I acknowledge that I have read and understand all of the above information. I herby authorize payment of any insurance benefits for unpaid services to the Atlantic Eye Physicians. I accept full responsibility for all out of pocket expenses which may be deductible, copayment, coinsurance, total cost for all non-covered services and understand that I am responsible for any balances or unpaid insurance claims.

Patient Signature: _____ **Date:** _____

Patient Representative's Name: _____ **Relationship to Patient:** _____