Neil M. Bealka, Jr., M.D., P.A.
Board Certified Ophthalmologist

Date: _____

WELCOME TO OUR OFFICE

PATIENT INFORMATION

Full Name _____
First MI Last
How would you like to be addressed by the staff? _____ Sex: M F
Home Phone (_____) _____ Cell/Wk Phone (____) _____
Street Address _____ City _____ State _____ Zip _____
Mailing Address _____ City _____ State _____ Zip _____
Date of Birth _____/_____/_____ Social Security No. _____-_____-_____
Employer _____
Name of Spouse (_____) or, if minor, Parent (_____) _____
Spouse's or Parent's Employer _____ Cell/Wk Phone (_____) _____

FAMILY MEMBERS / EMERGENCY CONTACTS

Names of other family members who have been seen here as patients:
_____
_____
Who should we contact in case of an emergency?
_____ Phone (_____) _____
I hereby authorize Dr. Neil Bealka, Jr., P.A. to release any information regarding my illness and treatment to the following person(s):
_____ Phone (_____) _____

REFERRED BY

PLEASE INDICATE HOW YOU WERE REFERRED TO OUR PRACTICE
___ I was referred by another *EYE DOCTOR,* Dr. _____
___ I was referred by my family doctor, Dr. _____
___ I was referred by a friend or family member _____
___Other _____
Primary Care Doctor _____ Phone (_____) _____
Primary Care Clinic Name/Address_____

PRIMARY INSURANCE COVERAGE

Please present your insurance cards along with this completed form at the front desk.

Primary Insurance Carrier _____
Policy Holder's Name _____ _____ _____
First MI Last
Policy Holder's SS No. _____-_____-_____ Date of Birth _____/_____/_____
Relationship to Patient _____ Employer _____ Cell/Wk Phone (_____)_____

SECONDARY INSURANCE COVERAGE

Secondary Insurance Carrier _____
Policy Holder's Name _____ _____ _____
First MI Last
Policy Holder's SS No. _____-_____-_____ Date of Birth _____/_____/_____
Relationship to Patient _____ Employer _____ Cell/Wk Phone (_____)_____

RESPONSIBLE PERSON

Who is responsible for payment? *(check one)* _____ Patient _____ Parent _____ Other
Responsible Person's Name _____ _____ _____
First MI Last
Relationship to Patient _____ Home Phone (_____) _____ Cell/Wk Phone (_____) _____
Address _____ City _____ State _____ Zip _____

(See Other Side)

PATIENT FINANCIAL POLICY

Your Insurance

- Dr. Neil Bealka, Jr., P.A. contracts with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service.
- If you have insurance coverage with a plan for which Dr. Neil Bealka, Jr., P.A. does not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the practice, and I agree to be bound by the terms. I also understand and agree that the practice may amend such terms from time to time.

CONSENT TO TREAT

I have requested medical services from Dr. Neil Bealka, Jr. on behalf of myself and/or my dependents. I agree to and understand that my eye(s) must be dilated in order for the doctor to thoroughly check the eye(s). I agree to and understand that my eye may need to be patched as a part of the treatment of my condition. I understand that if my pupils are dilated or my eye is patched after the eye exam, I may not be able to safely operate a motor vehicle and that the staff and Dr. Neil Bealka, Jr. request and strongly urge that I arrange alternate transportation.

ASSIGNMENT OF BENEFITS

I understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. I understand that if I fail to provide all necessary information to file my insurance claim, I will be required to pay all charges in full at the time services are rendered. A photocopy of this assignment is to be considered as valid as the original. I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other heath/medical plan, to issue payment check(s) to Dr. Neil Bealka, Jr. for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby further authorize Dr. Neil Bealka, Jr. to (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of one year. This order will remain in effect until revoked by me in writing.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES AND PATIENT BILL OF RIGHTS

I have been made aware of and/or reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Patient/Responsible Party Signature Date

_____ _____

Witness Date