**Ravi Krishnan, M.D., P.A.** **Kevin W. Voigt, O.D.**

| First Name | Middle Initial | Last Name | |
|---|---|---|---|
| **Address** | **City and State** | **Zip Code** | **Home Phone:** ( ) |

| Cell Phone | Employer: | Occupation: | Work Phone: |
|---|---|---|---|
| ( ) | | | ( ) |

| Social Security # | DOB | Race | Ethnicity | Sex |
|---|---|---|---|---|
| | | | | [ ]M [ ]F |

| Marital Status | Contact Preference: (circle one) | E-Mail Address |
|---|---|---|
| [ ] S [ ] M [ ]Other | Home Cell E-mail | |

| Emergency Contact Name | Phone | Relationship |
|---|---|---|
| | ( ) | |

**<u>GUARANTOR INFORMATION</u> Complete this section only if the patient is <u>NOT</u> responsible for this account.**

| Name | Relationship | DOB: | Sex | Social Security# |
|---|---|---|---|---|
| | | | [ ]M [ ]F | |

| Address | City, State, Zip | Contact Phone |
|---|---|---|
| | | ( ) |

| Employer: | Referring Physician or Physician last seen: |
|---|---|
| | |

| PHARMACY: | Address | Phone: |
|---|---|---|
| | | ( ) |
| **1. PRIMARY INSURANCE NAME:** | **Identification Number** | **Group Number** |
| **Name Of Policy Holder** | **Date Of Birth** | **Relationship To Policy Holder** |
| **2. Secondary Insurance Name:** | **Identification Number** | **Group Number** |
| **Name Of Policy Holder** | **Date Of Birth** | **Relationship To Policy Holder** |

**I request that payment of authorized insurance benefits be made on my behalf to the provider indicated above for any services furnished me, authorize any holder of medical information about me or my dependent to release to the to the insurance company any information needed to determine these benefits payable for related services. A photocopy of the assignment is to be considered as valid as the original until revoked. I understand that I am financially responsible for all charges whether or not covered by said insurance. I authorize Ravi Krishnan M.D., P.A. and The Eye Institute of Corpus Christ to treat my condition.**

**Patient Signature:** ______________________________ **Date**__________________

**Ravi Krishnan, M.D., P.A.** **Kevin W. Voigt, O.D.**

# Financial Arrangements

## We are committed to providing you with the best possible care. We are here to help you.

- **If you have medical insurance, we will file a claim with your insurance company as a courtesy. In agreement with your insurance the provider is required to collect co-payment, deductible, or co-insurance at the time of service. We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility. We realize temporary financial problems may affect payment of your account. If such problems arise you will need to make payment arrangements with the billing department.**
- **Returned checks and overdue balances are subject to additional fees.**
- **Your insurance is a contract between you, your employer, and the insurance company. Our fees fall within the acceptable range by most insurances, and therefore are covered up to the maximum allowance determined by each carrier. Not all services are covered by your insurance. The individual requirements of your plan are your responsibility to comply with. If your plan requires that we use certain lab facilities or hospitals, or requires referrals or pre-certification or hospital admissions, you must remind us each time this is needed. We will make every effort to help you but we do not take responsibility for all of the requirements of the many plans.**

# Authorization For Release of Protected Health Information

## Release my protected health information to the following person(s)

## Pertains to relatives or anybody that would be calling concerning your health information.

| Name: | Relationship: | Phone: |
|---|---|---|
| Name: | Relationship: | Phone: |
| Name: | Relationship: | Phone: |

**If you have special instructions on how your health information should be released please list specifications here:**

________________________________________________________________________

____________________________________________________________________

## I understand that I have the right to revoke this authorization, in writing, at any time.

# Notice of Privacy Practices

**Upon request I may receive a copy of The Eye Institute of Corpus Christi's Medical Notice of Privacy Practices, which is a statement that explains how my medical information will be used and disclosed.**

**Patient Name:** ________________________________________ **DOB:** ____________________

**Signature:** ____________________________________________ **Date:** ____________________

**Authorized representative must submit copies of legal documentation supporting authority to act on the patient's behalf.**