ALLEGHENY OPHTHALMOLOGY ASSOCIATES

WELCOME TO OUR OFFICE!

1. PATIENT'S NAME: _____ MARITAL STATUS: M S W D

   ADDRESS: _____ CITY & ZIP: _____

   HOME PHONE: _____ BUSINESS PHONE: _____

   CELL #: _____

   SOCIAL SECURITY NO: _____ BIRTHDATE: _____ AGE: _____ SEX: M F

2. GUARANTOR–(IF CHILD):_____ RELATIONSHIP _____

   PHONE_____ WORK PHONE _____

   ADDRESS: _____ CITY & ZIP _____

   BIRTHDATE: _____ SS # _____OTHER INFO_____

3. NAME OF NEAREST RELATIVE NOT LIVING WITH YOU & PHONE # _____

4. MAY WE CONTACT YOU BY PHONE OR MAIL TO, CONFIRM, GIVE TEST RESULTS, ETC. Y N

5. EMPLOYER NAME & ADDRESS _____

_____

_____

6. IS PATIENT A STUDENT: Y N 7. FAMILY DR.: _____ PHONE: _____

   ADDRESS: _____

8. INSURANCE INFORMATION: PLEASE INCLUDE ALL LETTERS & NUMBERS

_____

_____

9. POLICY HOLDER NAME _____BIRTHDATE _____

10. VISION COVERAGE?: Y N /NAME OF CARRIER _____

    VISION INS, ID # _____ GROUP #_____

PLEASE BRING ALL INSURANCE CARDS WITH YOU SO WE CAN MAKE COPIES!

INSURANCE AUTHORIZATION & ASSIGNMENT **PLEASE READ AND SIGN**

I hereby authorize Michael B. Sigal, MD, Dr. Scott L. Portnoy, MD, or Michael A. Alunni, MD to release information to carriers concerning my illness and treatment. I hereby assign to the Physicians all payments for medical services by them to myself or my dependents. I understand that I am responsible for payment to this office within the stated policy. I understand that I am responsible for the refraction fee (checking of glasses) which insurance does not cover and copays and deductibles and non-covered charges.

* * * SIGNATURE _____ DATE _____

11. IS THIS A WORK RELATED INJURY? Y N / IF YES, PLEASE FILL IN THE FOLLOWING:
    DID YOU FILE AN INJURY REPORT? Y N DATE OF INJURY _____

    COMPANY NAME: _____

    ADDRESS: _____

    PHONE: _____

SIGNATURE ON FILE

BENEFICIARY'S NAME (PRINT) _____ MEDICARE IDENTIFICATION NO. _____

1. MEDICARE / OR EQUIVALENT

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE ON MY BEHALF TO DRS. SIGAL, PORTNOY, AND ALUNNI FOR SERVICES FURNISHED ME BY DRS. SIGAL, PORTNOY, AND ALUNNI. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO RELATED SERVICES.

I UNDERSTAND 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 OF ELSEWHERE ON THE OTHER APPROVED CLAIM FORMS, MY SIGNATURE AUTHORIZES RELEASING THE INFORMATION TO THE INSURER OR AGENCY SHOWN.

DRS. SIGAL, PORTNOY, AND ALUNNI, ACCEPTS THE CHARGE DETERMINATION OF THE MEDICARE CARRIER. DRS. SIGAL, PORTNOY, AND ALUNNI, AS THE FULL CHARGE, AND THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, COINSURANCE AND NONCOVERED SERVICES. COINSURANCE AND THE DEDUCTIBLE ARE BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE CARRIER.

SIGNATURE _____ DATE _____

2. MEDIGAP

IF A MEDIGAP POLICY OR OTHER HEALTH INSURANCE IS INDICATED IN ITEM 9 OF THE HCFA 1500 FORM OR ELSEWHERE ON THE OTHER APPROVED CLAIM FORMS, MY SIGNATURE AUTHORIZES RELEASE OF THE INFORMATION TO THE INSURER OR AGENCY SHOWN. I REQUEST THAT PAYMENT OF AUTHORIZED SECONDARY INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO DRS. SIGAL, PORTNOY, AND ALUNNI.

SIGNATURE _____ DATE _____

3. OTHER INSURANCE

I HEREBY AUTHORIZE PAYMENT OF MY MEDICAL AND SURGICAL INSURANCE BENEFITS TO DRS. SIGAL, PORTNOY, AND ALUNNI. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. IF CO-PAYMENTS AND/OR DEDUCTIBLES ARE DESIGNATED BY MY INSURANCE COMPANY OR HEALTH PLAN, I AGREE TO PAY THEM TO DRS. SIGAL, PORTNOY, AND ALUNNI. I AUTHORIZE DRS. SIGAL, PORTNOY, AND ALUNNI TO RELEASE ANY INFORMATION REQUIRED TO PROCESS ANY AND ALL CLAIMS FOR REIMBURSEMENT ON MY BEHALF. A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL.

X _____ _____

SIGNATURE DATE