

Guardian Eye Associates, PLC

Conrad: _____ Frey: _____ Wayburn: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Social Security: _____ Date of Birth: _____

Sex: F M Marital Status: S M W D

Employer: _____ Work Number: _____

SPOUSE/GUARDIAN INFORMATION

Name: _____ Date of Birth: _____

Relationship: _____ Social Security: _____

Emergency Contact: _____ Phone Number: _____

Referred By: _____

I AUTHORIZE GUARDIAN EYE ASSOCIATES TO CONTACT ME AT THE FOLLOWING E-MAIL ADDRESS:

_____ @ _____

I certify to the best of my knowledge that the above information is complete and correct. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to this office for any service furnished to me by the provider. I authorize the release to Medicare or any other insurance carrier and/or their agents any information necessary to determine benefits payable.

Signature of Patient/Parent or Guardian: _____ **Date:** _____

I accept full responsibility for payment of my bill including any deductibles, non-covered services or in the event of default, any reasonable attorney's fees and cost of collection. I will be responsible for obtaining any referral which my insurance may require from my Primary Care Physician prior to being seen in this office. If seen without a referral, I will be responsible for any services rendered.

Signature of Patient/Parent or Guardian: _____ **Date:** _____
