Liebergall & Paskowski
EYE ASSOCIATES, M.D., P.C.

REGISTRACION
REGISTRATION

Acct. #: ____________

Co-pay________ ☐ PPO ☐ HMO

GENERAL

Patient Name: ____
LAST NAME / APELLIDO FIRST NAME / PRIMER NOMBRE MIDDLE INITIAL / INICIAL

Birth Date: ______/______/______ SS #: ______-______-______ Phone: ____________
FECHA DE NACIMIENTO SEGURO SOCIAL # TELEFONO #

Address: ____________________ Cell Phone: ____________
DIRECCION CELULAR #

Apt #: ____________________ Fax: ____________

City: ____________ State: ________ Zip: ________ Email: ____________
CIUDAD ESTADO C. POSTAL

Sex: M ☐ F ☐ Age: ________ Who referred you to this office: ____________
SEXO EDAD

Primary Care Physician: ____________________ Physician Phone: ____________
DOCTOR PRIMARIO TELOFONO DEL DOCTOR

EMPLOYER

Employer: ____
EMPLEADOR

Address: ____
DIRECCION

City: ____________ State: ________ Zip: ________ Phone: ____________
CIUDAD ESTADO C. POSTAL TELEFONO

INSURANCE

Primary Insurance: ____________________
PRIMER SEGURO

Address: ____________________
DIRECCION

____

Policy #: ____________ Group #: ____________
POLIZA # GRUPO #

Policy Holder Name: ____________________
NOMBRE DEL ASEGURADO

Birth Date: ___/___/___ **SS #:** ______-______-______
FECHA DE NACIMIENTO SEGURO SOCIAL #

Patient Relation To Insured: ____________________
RELACION CON EL ASEGURADO:

Secondary Insurance: ____________________
SEGUNDO SEGURO

Address: ____________________
DIRECCION

____

Policy #: ____________ Group #: ____________
POLIZA # GRUPO #

Policy Holder Name: ____________________
NOMBRE DEL ASEGURADO

Birth Date: ___/___/___ **SS #:** ______-______-______
FECHA DE NACIMIENTO SEGURO SOCIAL #

Patient Relation To Insured: ____________________
RELACION CON EL ASEGURADO:

437-0102-50-60-0005

PAYMENT AUTHORIZATION

I authorize payment of medical benefits to Liebergall & Paskowski Eye Associates, M.D., P.C., for services rendered.

I authorize this office to furnish my insurance carriers with any information relevant to my claim, and to make direct payment when accepted.

____
Signature / FIRMA

____
Date / FECHA

MEDICARE RELEASE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Liebergall & Paskowski Eye Associates for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

____
Signature / FIRMA

____
Date / FECHA

TREATMENT WAIVER

I agree that if Liebergall & Paskowski Eye Associates treats me or my child and I do not obtain the required referral form, properly dated, then I will be responsible for payment of these charges and can be billed directly.

I also understand that certain examinations, including **refraction** (vision testing for glasses), may be a **non-covered service** by my insurance company. Such charges will be my responsibility and may be non-reimbursable by insurance.

____
Signature / FIRMA

____
Date / FECHA