DR. MATTHEW E. SCHMIDT & ASSOCIATES

Name: **Birthdate** _____

Last _____ **First**_____ **MI**__ **Male**___ **Female**___

Address_____

City_____ **State**_____ **Zip Code**_____

Phone: Home_____ **Work** _____ **Cell**_____

Contact Preference (circle one): Home, Work, Cell **E-mail**_____

Primary Language: English Other_____ **Ethnic Origin** (circle one): Non-Hispanic Hispanic

Race (circle one): American Indian Alaskan Native Asian Black American White Other_____

Medical Insurance – HMOs require a referral

Name of Insured person: _____

Insured DOB:_____ **Relationship to Patient:** _____

Billing address (if different than patient's): _____

State_____ **Zip Code**_____ **Phone**_____

Insurance: Primary_____Secondary_____Tertiary_____

Do you have <u>any</u> medical assistance through the State of Illinois? Yes or No

Is this medical insurance an HMO? If Yes, *you must obtain a referral prior to your appointment.*

Routine Vision Plans

Do you have a ROUTINE Eye Plan? **Vision Service Plan = VSP** _____ **EYEMED**____ **DAVIS**____

(ALL DOCTORS) (EYEMED,DAVIS = DR. MAYNARD ONLY)

Please fill out the following information which is required for authorization:

Name of Policy Holder _____ **Birthdate** _____

Last 4 digits of Social Security Number _____

Financial Agreement

- I hereby assign to the physician(s) payment for services rendered to myself or my dependents. I permit a photocopy of my signature to be used in place of the original for this purpose.
- I understand I am responsible for copayments, deductibles and non-covered services, including refraction fees, **<u>at the time of service</u>**.
- **Refraction fees are considered routine eye care and are not covered by Medicare and most private payors.** A refraction is a necessary part of a routine eye exam for the prescription of glasses and contact lenses. It is also necessary for the diagnoses of certain eye diseases.
- I understand I am responsible for HMO referrals. If I fail to provide a required referral I will be responsible to pay the full amount **<u>at the time of service.</u>**

Date_____ **Signature of patient/insured**_____