NORTHWEST OPHTHALMOLOGY

LAWRENCE D. WOLIN, M.D.
1602 W. Central Road
Arlington Heights, IL 60005
Phone: (847) 255-3515

Patient Information

Demographics

LAST NAME	FIRST	MI	DATE	
STREET ADDRESS		APT. #	SOCIAL SECURITY #	
CITY			STATE	ZIP CODE
BIRTH DATE	AGE	SEX ☐ M ☐ F	MARITAL STATUS ☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED	
HOME PHONE ( )		WORK PHONE ( )		
EMPLOYER NAME AND ADDRESS			POSITION / DEPARTMENT	
SPOUSE NAME			WORK PHONE ( )	
EMERGENCY CONTACT			EMERGENCY PHONE ( )	

Billing

GUARANTOR (FINANCIALLY RESPONSIBLE PERSON) NAME		RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER _____	
STREET ADDRESS	APT. #	PHONE ( )	
CITY		STATE	ZIP CODE
PRIMARY INSURANCE		POLICY HOLDER	
POLICY ID #	SOCIAL SECURITY #	INSURED'S B/D	DATE OF INCIDENT

Referral

WHOM MAY WE THANK FOR TELLING YOU ABOUT OUR PRACTICE?		☐ FRIEND/FAMILY ☐ M.D. ☐ OPTOMETRIST ☐ PATIENT ☐ OTHER _____	
STREET ADDRESS	CITY	STATE	ZIP CODE
PRIMARY CARE DOCTOR NAME		PHONE ( )	
STREET ADDRESS	CITY	STATE	ZIP CODE

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Agreement of Responsibility

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductibles and co-insurance may be collected at the time of service. I understand that I am financially responsible for charges not covered by my insurance company.

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in their medical judgment.

Release of Information/Assignment of Benefits

I authorized use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance company. I understand that provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under any insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me.

Medicare Authorization

Medicare Number:_____

I request payment of authorized Medicare benefits be made on my behalf to Lawrence D. Wolin, M.D., S.C. for any services furnished by me by that physician/supplier. I authorize the holder of medical information about me to release to Medicare and it's agents any information needed to determine these benefits payable to related services.

I understand that my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized the release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and the uncovered services, co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

This agreement is in effect until revoked in writing by the patient.

Name:_____ Date: _____

Signature: _____