Pankratz Eye Institute
3135 Middle Road
Columbus, IN 47203
Phone: *812-373-7777*
Fax: 812-373-0772

Michael J. Pankratz, M.D.
Ophthalmologist & Eye Surgeon
Carissa L. Klaas, M.D.
Retinal Specialist & Eye Surgeon

PATIENT INFORMATION:

Patient Name: Male ❑ Female ❑
First MI Last Date of Birth Sex

Address:
Number Street City State Zip + 4

Email address: Home Phone: Cell Phone:

Soc. Sec.#: Marital Status: Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑

Place of Employment: Work Phone:

May we contact you at your work place? Yes No

Ethnicity: Hisp. or Latino ❑ Not Hispanic or Latino ❑

Race: Asian ❑ Black or African American ❑ White ❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander ❑

Optometrist/Eye Doctor: Family Doctor:

Referring Doctor:

How did you choose our practice?

If referred by family or friend, please list:

EMERGENCY CONTACT Name: Relationship

(Outside your home)
Address: Phone

CONSENT FOR METHOD OF CONTACT

I acknowledge and agree that the Pankratz Eye Institute, LLC or any of its affiliates, including any bill collection or debt collection companies may contact me by telephone or by text message to any telephone number I provide to you or at any other telephone number associated with my account, including wireless telephone numbers, which I understand could result in charges. I further agree that you may use any method of contact to any of these telephone numbers, including prerecorded or artificial voice messages, text messages and automatic dialing devices. You may also contact me via electronic mail using any email address I have provided to you for use. I acknowledge the contact information provided to you is private to me and I take sole responsibility for maintaining the privacy of any of the information I provide to you. I further understand that in order to revoke my consent to be contacted, I must send a written revocation of my consent to the Pankratz Eye Institute, LLC or to the affiliate contacting me on behalf of the Pankratz Eye Institute, LLC.

Name [please print]: _____

Signature: _____ Date:_____

RESPONSIBLE PARTY INFORMATION: *(If different from patient)*

Name:				Phone:	
Address:					
Number	Street	City	State	Zip + 4	County
Social Security #:			Date of Birth:		

PRIMARY INSURANCE INFORMATION:	**SECONDARY INSURANCE INFORMATION:**
Company Name:	Company Name:
Policy Holder's Name:	Policy Holder's Name
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Soc. Sec. #	Policy Holder's Soc. Sec. #
Insurance ID #:	Insurance ID #:
Employer:	Employer:
Employer's Phone #:	Employer's Phone #:

MEDICARE RECIPIENTS

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare or other insurance claims. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for covered Medicare or other insurance services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare or other insurance for payment. I request that payment under the medical insurance program be made either to me or on my behalf to Pankratz Eye Institute, LLC.

OTHER INSURANCE

I understand that my insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered for my dependents or myself.

FINANCIAL POLICY

In accordance with the Financial Policies I have received and read, I hereby authorize payment of medical benefits to the Pankratz Eye Institute, LLC, for any services rendered to me. I also understand that I am financially responsible for any balance amount not covered by my insurance, as well as all co-payments, coinsurance fees, and applicable deductibles. Should my account be referred for collection, I understand that I shall pay all attorney fees, court costs, and costs of collections.

Name [Please Print]: _____

Signature of Patient or Guardian _____Date_____