Columbus Laser Vision

William F. Columbus M.D. **Robert A. Columbus O.D.**
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344 Wilkes Barre Township Blvd.
Wilkes Barre, PA 18702-6708

4626 Street Rd
Trevose, PA 19053-6612

100 Colonial Rd
Harrisburg, PA 17101-6232

PATIENT INFORMATION

Patient Name: ______________________________ Sex: __________ Marital Status: ________________

Patient Address: ____

City, State, Zip Code: ____

Phone Number: ______________ Birthdate: ___________ Social Security Number: ________________

Occupation & Employer: ____

Family / Referring Physician: ____

INSURANCE INFORMATION

Please attach photocopy of insurance card(s)

Subscriber Name: __________________________ Relationship to Patient: ________________________

Primary Insurance Company: ____

Member ID #: ______________________________ Group # (if applicable) ________________________

Subscriber Date of Birth: ________________________ Subscriber SS Number ____________________

ASSIGNMENT & RELEASE

I, the undersigned assign directly to Columbus Laser Vision, any or all insurance benefits, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the above insurance(s). I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Additionally, I have received or was offered information on my HIPAA rights and I was provided an opportunity to ask the provider of service any questions.

Responsible Party Signature: ____

Relationship to Insured: _______________________________ Date: ____________________________