# Mary Kelly Green, MD, PLLC

**Account:**_____ **Date:** _____

## PATIENT INFORMATION

Full Name:_____ Preferred Name: _____
*Last* *First* *MI*

Date of Birth:_____ Age:_____ Social Security #:_____ Sex: M F Marital Status: Single Married Widow(er)

Mailing Address:_____ City:_____ State: _____ Zip:_____

Home #:_____*Preferred?*__ Cell #:_____ *Preferred?*__ Email: _____

Employment Status: ☐ Employed ☐ Retired ☐ Student ☐ Part-Time ☐ Other _____

Employer: _____

Name of Spouse ☐ or, if minor, parent ☐ _____ Phone: _____

## EMERGENCY CONTACTS

Who should we contact in case of an emergency?

_____ Phone: _____ Relationship:_____

## AUTHORIZATION

I hereby authorize Mary Kelly Green, MD, PLLC to release any information regarding my illness and treatment to the following person(s):

Name: _____ Relationship:_____ Phone: _____

Name: _____ Relationship:_____ Phone: _____

## PRIMARY CARE PHYCIAN / REFERRAL INFORMATION

Primary Care Doctor:_____ Phone: _____

Primary Care Clinic Name/Address: _____

I was referred by Dr. _____

## PRIMARY INSURANCE COVERAGE

*Please present your insurance card along with this completed form at the front desk.*

Primary Insurance Carrier:_____ Address:_____

Policy Holder's Name:_____

Policy Holder's SS #:_____ Date of Birth: _____

Relationship to Patient:_____ Employer:_____ Phone: _____

## SECONDARY INSURANCE COVERAGE

Secondary Insurance Carrier:_____ Address: _____

Policy Holder's Name:_____

Policy Holder's SS #:_____ Date of Birth: _____

Relationship to Patient:_____ Employer:_____ Phone: _____

## RESPONSIBLE PERSON

Who is responsible for payment? ☐ Patient ☐ Parent ☐ Guardian ☐ Other_____

Responsible Person's Name: _____

Relationship to Patient:_____ Phone # 1:_____ Phone # 2: _____

Address:_____ City:_____ State:_____ Zip:_____

## PATIENT INFORMATION

To reduce confusion and misunderstanding between our patients and practice, Mary Kelly Green, MD, PLLC has adopted the following policies. Please discuss any questions regarding these policies with our office manager or business office representative. For your convenience we accept cash, checks, Visa, MasterCard, Discover, American Express and CareCredit. The return of a check (electronic or paper) issued to Mary Kelly Green, MD, PLLC will result in a $30.00 returned check fee to the issuer. **Checks not accepted without current/valid Texas driver license.**

**Your Insurance**

- Mary Kelly Green, MD, PLLC contracts with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement with and will only require you to pay the authorized copayment, deductible, coinsurance or any portion of services that are considered "patient responsibility".
- If you have insurance coverage with a plan for which Mary Kelly Green, MD, PLLC does not have a prior agreement, payment is due at the time services are rendered.
- In the event that your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. We do not make any guarantee of benefit coverage and your insurance plan, as always, has the final determination of coverage.
- For services provided in an ambulatory surgery center or hospital, an estimate of fees that you will be responsible for will be estimated and is payable before your surgery or procedure is done. Any remaining balance after your claim has been processed is due upon receipt of a statement from our office.

**Minor Patients**

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the practice and I agree to be bound by the terms. I also understand and agree that the practice may amend such terms from time to time.

## CONSENT TO TREAT

I have requested medical services from Mary Kelly Green, MD, PLLC on behalf of myself and/or my dependents. I agree to and understand that my eye(s) may be dilated in order for the doctor to thoroughly check the retina of the eye. I agree to and understand that my eye may need to be patched as part of the treatment of my condition. I understand if my pupils are dilated or my eye is patched after the eye exam, I may not be able to safely operate a motor vehicle and that the staff and doctors of Mary Kelly Green, MD, PLLC request and strongly urge that I arrange alternate transportation.

## ASSIGNMENT OF BENEFITS

I understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. I understand that if I fail to provide all necessary information to file my insurance claim, I will be required to pay all charges in full at the time services are rendered. A photocopy of this assignment is to be considered as valid as the original. I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) to Mary Kelly Green, MD, PLLC for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

## AUTHORIZATION TO RELEASE INFORMATION

I hereby further authorize Mary Kelly Green, MD, PLLC to (1) release my information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of two years. This order will remain in effect until revoked by me in writing.

## ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY RIGHTS

I have been made aware of and/or reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand I am entitled to receive a copy of this document.

Signature:_____ Date:_____

PLEASE PRINT FULL NAME:_____ Relationship to Patient:_____