PATIENT INTAKE & HEALTH HISTORY

Patient Legal Name:	**DOB:**	**Date:**

Your minimum exam copayment today could be: Routine $_____ Medical $_____ Contact Fit $_____ (if applicable)

Final charges will be determined once your exam is completed.

Please mark your method of payment: Cash: _____ Check: _____ Debit/Credit: _____

PATIENT INFORMATION

Preferred Name	Gender	Age
Home Phone #	Home Address	
Cell Phone #		
Email Address	Employer	
SSN (if ins. requires)	Occupation	

RESPONSIBLE PARTY (if patient is a minor)

Parent/Guardian Full Name	Relationship to Patient
Date of Birth	Primary Phone #
Address	Email Address

VISION INSURANCE	MEDICAL INSURANCE
Insurance Carrier	Insurance Carrier
Policy Number	Policy Number
Group Number	Group Number
Secondary (if applicable)	Secondary (if applicable)

POLICY HOLDER INFORMATION (if different from patient)

Name (as shown on card)	Address
SSN (if ins. requires)	
Date of Birth	Primary Phone #

PRIMARY CARE INFORMATION

Physician Name	Phone #

☐ **By checking this box I agree to have my records or diagnosis information shared with my physician.**

PHARMACY INFORMATION

Pharmacy Name	City & Zip Code

HIPAA PRIVACY NOTICE

The HIPAA Policy was available to read during my office visit. _____ (patient initials)

We do not share your personal health information (PHI) with anyone without your authorization. In case of emergency, please provide information for one individual with whom we may share your medical records.

Authorized Individual _____ Phone Number _____

STATEMENT OF FINANCIAL RESPONSIBILITY

In order for my eyecare provider to service my account, or to collect any amounts I may owe, I agree that I may be contacted at any number or address I have provided above or during a previous encounter. I understand that my eye exam and any optional contact lens fitting copayments are due today, and glasses or contact lenses may not be dispensed if those copayments are unpaid. I also understand that fees for services are non-refundable and non-negotiable, and any contact lens prescriptions given are valid for one year per federal law. I furthermore agree to pay any collection expenses incurred to collect any amount I may owe due to non-payment. I understand that I am solely responsible for the cost of all non-covered items, as outlined in detail on my receipt which includes: the specific date of service, description of each procedure/service, and the amount I am responsible for paying out-of-pocket; I certify that I have been informed of all items and cost. I authorize the release of my information for my eyecare provider to file all insurance claims if we are a participating provider for your plan. However, there is no guarantee of benefit information and/or coverage and if my insurance denies payment for any claims submitted, I will be responsible for full payment and can contact my insurance company directly should there be a dispute. My eyecare provider can also supply me with an itemized statement which I may submit to my insurance carrier, should I need to submit for reimbursement. I understand that any follow-up appointments related to a contact lens evaluation are included for three months after the initial fitting, and should there be any follow-up appointments required after the three months have past, I am responsible to pay the professional service fee. Additionally, I know that any optional testing that I have verbally agreed to pay for, is my responsibility to do as such on the date of service. Should I receive a medical examination, I understand that my major medical insurance will be billed and I will be responsible for any deductibles, coinsurance or copayments that may be due.

☐ **I have read and understand the Statement of Financial Responsibility.**

Signature of Patient (or Parent/Guardian) _____ Date _____