

# **Patient Information Form**

**Important Note: DO NOT send this information via email.**

**Save this form to your computer, print it and bring it with you to your exam.**

**In order to serve you properly we need the following information. All information is confidential. Please print.**

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex: M F Social Security Number \_\_\_\_\_

Employment Status: Employed Full Time Student Part Time Student None

Employer \_\_\_\_\_ Marital Status: Single Married Other

Primary Care Physician \_\_\_\_\_ Physician's phone # \_\_\_\_\_

Name and address of clinic \_\_\_\_\_  
\_\_\_\_\_

Mother's name if patient is minor \_\_\_\_\_

Father's name if patient is minor \_\_\_\_\_

## **Insurance Information**

Name of Vision Insurance Company \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber ID# \_\_\_\_\_ Group ID# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_

Name of Medical Insurance Company \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber ID# \_\_\_\_\_ Group ID# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_

*Do you have a secondary vision or medical insurance?* Yes No

Name of Medical Insurance Company \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_

## ***Responsible party if other than patient***

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

## Office Policies

### 1. Payment at Time of Service

**You are responsible for any co pays, co-insurance, deductible and other non-covered services or materials the day services are rendered.** If you are a self pay patient and/or your insurance cannot be verified prior to your appointment you will be required to pay in full the day services are rendered. We accept cash, personal checks, MasterCard, Visa, American express, Discover card and Care Credit. If you are being seen for any ongoing medical problem, co pays are due at each and every visit. If you foresee any payment problems please speak to our office manager prior to your appointment.

### 2. Claims Filing

As a courtesy to our patients, we will file claims with your insurance company. We will do our best to accurately verify benefits for services and/or materials, however, benefits quoted by your insurance carrier **are not a guarantee of payment.** Should your insurance deny a claim for any reason you will be responsible for any remaining balances as directed by your insurance. When required by your insurance company, you are directly responsible for obtaining a referral from your Primary Care Physician.

### 3. Cancellation Policy

We request 24 hours notice to cancel or reschedule an appointment. We understand that emergencies do come up. Please call our office as soon as possible if you cannot keep your appointment so that other patients in need of care can be seen.

### 4. After Hour On Call Service

We do provide after hours telephone triage advice given by one of our doctors. This is for medical eye emergencies only. Please call during regular office hours for things such as prescription refills, contact lens replacement, and contact lens and glasses prescriptions.

The number is 1-800-854-8314 to reach the on call service who will then contact our doctor on call. If you have not received a response within 30 minutes please call back.

### 5. Returns and Refunds

We want you to be completely happy with your eyewear purchase! We will do everything we can to make sure your glasses are made correctly. If there are any problems please let us know within 30 days of picking them up. Most patients are very happy with the high quality progressive lenses we provide; however some patients do still occasionally have adaptation problems. We will be more than happy to remake your lenses into single vision or bifocal lenses at no additional charge; however no refund will be given for the cost difference of the progressive lenses.

### 6. Patient Billing and Collections

Patients that receive a statement from our office are expected to remit full payment upon receipt unless previous payment arrangements were made with our billing office. If your account must be referred to an outside collection agency for non-payment, a fee will be added to your account to cover the expense incurred from the agency. Patients in collections must make payment arrangements prior to scheduling another appointment with our office. **If you receive a billing statement that you do not understand, please contact the office where services were rendered.**

I authorize Eye Care Associates to act as my agent in applying for insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Eye Care Associates on my behalf. I authorize any holder of medical information about me to release information needed to determine benefits payable for related services. If I have additional insurance, my signature authorizes release of the above medical information to any insurer or agency I have given, and authorizes my doctor to act as my agent above.

With my signature below I confirm that I have been informed of and agree with the above outlined policies and insurance authorization. Unless revoked by me in writing, this authorization is effective for my lifetime.

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(Lifetime Patient Signature)

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(Date)

