Welcome to the Eye Doctor's Office

Patients Information

Legal Name: _____
First M.I. Last

Preferred Name: (Please call me): _____

Circle one: I am: Dr . Mr. Mrs. Ms Miss Jr. Sr. I II III

Circle one: I am: Married Single Domestic Partner

Address: _____

Date of Birth: ____/____/____ Age: _____ Sex: M or F

City: _____ State: _____ Zip: _____

Social Security Number: _____/_____/_____

Home Phone: (_____)_____-_____

Daytime Phone: (_____)_____-_____

Cell Phone: (_____)_____-_____

Your Email will ONLY be used for in office professional purposes such as; recall, confirming appointments & for our contact lens patients to order their contact lenses on online. *It will never be shared with any outside persons or sources.*

ARE YOU PLANNING TO GET NEW EYEGLASSES TODAY?
YES NO NOT SURE
ARE YOU PLANNING TO GET NEW CONTACT LENSES TODAY?
YES NO NOTSURE

Preferred Email: _____

Employer: _____

Occupation: _____

Drivers License #_____State_____Exp_____

For New Patients
Who may we thank for referring you?
If not referred, how did you hear about our office?

Spouse or Parent Information (If applicable)

Name: _____

Relationship to Patient: _____ DOB: ____/____/____

Address: _____

Employer: _____

Social Security Number: _____-_____-_____

Cell Phone: (_____)_____Work( )_____

Drivers License #_____State_____Exp_____

Vision/Medical Insurance Card Information

This office is a medical facility. Your medical insurance may often times cover advanced testing and medical treatment of the eyes. Diseases of the body can show up in the eyes. If the doctor determines the need for additional medical testing or treatment, the following information will help us file your claim.

Employee Name:_____ DOB___/___/___ Sex M or F

Company/Employer Name:_____

Relationship to Patient: Self Spouse Child F/T Student Other

Circle One: I am employed F/T P/T Self Employed Retired Not Employed

Insured's ID# _____ Group#_____SS#_____

Medical Plan Name _____Vision Plan Name_____

Acknowledgment of Notice of Privacy Practices

The Federal Law requires that we make every effort to inform you, the patient of your rights related to your personal health information.
Please check only one below:

___**Yes**, I **have** read or had explained to me by this office the NPP & I wish to continue my care with The Eye Doctor's Office under said terms.

___**No**, I **have not** read this office's NPP but, I was given the opportunity to read it upfront and declined. I wish to continue my care with The Eye Doctor's Office under the terms.

I acknowledge that I was offered a copy of the Notice of Privacy Practices for The Eye Doctor's Office updated 03/09/2020. If you are signing for a minor, you attest that you have legal authority to make medical decision for the minor. SIGNATURE:

PRINT NAME_____

Release of Health Information to Family, Friends and Others

(Please check only one below)
___**Yes, I authorize** all persons listed below the ability to receive materials in my absence and/or information on my behalf.

Name:_____Relationship_____Date_____

Name:_____Relationship_____Date_____

___**No, I do not authorize** any persons the ability to receive materials or information on my behalf. I choose to come myself.

Financial Assignment & Release
(Signature Required)

*** I, the undersigned, assign directly to American Eye Care Centers, Inc. DBA: The Eye Doctor's Office, Inc., Dr. Bob Consor, and Dr. Jenifer Nguyen all insurance benefits, if any, otherwise payable by me or to me for services rendered.**

*** I understand that I am financially responsible today for all fees. I also agree that I am financially responsible to reimburse any and all fees for services and materials not collected in full at the date of service or should my insurance or vision plan deny payment for services or materials rendered.**

*** I further understand that after 60 days from the date my services or claim is filed I agree to pay for any unpaid balances on my account as a result of denial in part or whole from my insurance carrier caused by; unmet deductibles, non covered materials or professional services, my negligence in fulfilling any paperwork, providing any required information requested of me by my insurance carrier or uncollected fees on service day.**

*** If I fail to reimburse said fees in a timely manner with the above stated office and should the need arise, I agree to pay any and all collection fees, court costs and attorney fees.**

*** If you do not inform us you have a vision plan or medical insurance before services are rendered, we will assume no coverage exists.**

*** I agree I am responsible to file my own claim if I discover I have vision or medical benefits after services or products are rendered.**

*** I agree this office with NO EXCEPTIONS will not back file claims, post authorize claims, or refund fees after services are rendered due to lack of notification of vision or medical benefits.**

X_____/____/____
Patient or Responsible Party Signature **Date Signed**

_____

Relationship to Patient **Print Name**