PATIENT INFORMATION

Family EyeCare North Inc

Please print

Mr. Mrs. Miss Ms Dr. Date of Birth :_____/_____/_____ SSN#:_____-_____-_____

Last Name:______________________________ First Name:______________________________ MI:___ Suffix:________

Home Address:______________________________ City:____________________ State:________ Zip:__________

Email Address:______________________________ Nickname:________________ Spouse:____________________

Home Phone (____) ____-______ Mobile Phone (____) ____-______ May we text you? ______

If child or minor, who is financially responsible?______________________________ Phone (____) ____-______

Address(If different from above)____

Employer Name:________________________ Phone (___)____-______ May we contact you at work?________

What type of work do you do?____________________ Do you use a computer more than 2 hours a day?_______

Primary Insurance:______________________ Policy Holder:______________ DOB__/___/___Relationship____________

Secondary / Supplemental Ins: ______________________________________

Policy Holder:______________ DOB___/___/____Relationship____________

Vision Insurance: ______________________ Policy Holder:______________ DOB___/___/____ Relationship____________

Family Physician/PCP:__________________________________ Phone: (___) ____-______

Pharmacy:____ Phone: (___) ____-______

Protected Health Information

I authorize Family EyeCare North Inc to share my medical information with ____________________________________

(relationship) ____________________ Signature ____

How did you hear about Family Eyecare North? Personal Referral: _________________________________

Internet Search

Other____

CONSENTS AND PRIVACY RECEIPT

I certify that this information is true and correct to the best of my knowledge.

I understand my insurance company will be billed on my behalf and I am responsible for all fees, deductibles, co-payments, and any unpaid portion of my bill. Payment in full is due at time of service unless other arrangements have been made.

I authorize the release or any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient Signature(or parent, if minor)____ Date _______________

I understand Family EyeCare North Inc and the Optical Showcase are obligated by law to protect my health information that identifies me as private. I have received or been offered the notice of privacy practices.

Patient Signature(or parent, if minor)____ Date _______________

Optical Waiver

Older frames are often discontinued by the manufacturer and replacement parts are generally not available. Placing new lenses or adjusting an old frame may create a pair of glasses that cannot be repaired later. I understand that Family EyeCare North Inc and the Optical Showcase cannot be held responsible for frame breakage when reusing my old frame.

Patient Signature(or parent, if minor)____ Date _______________

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Family EyeCare North Inc for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

Refractive Services: $25

Highmark Security Blue, Freedom Blue, Medicare and some Medicare Advantage Plans

The refraction is the part of the eye examination performed by your doctor to determine the prescription power for your eyeglasses and/or contact lenses.

Medicare and your medical insurance carrier does not consider refraction services medically necessary, thus your medical insurance carrier will allow billing of tests for ocular health assessment but not the cost of a refraction.

Patient Signature ____ Date _______________