Allisonville Eye Care Center, Inc.

Patient Information

Patient Name Miss / Ms. / Mrs. / Mr. / Dr. ____
First Middle Last Preferred Name

Date of Birth _____/_____/__________ Social Security Number _____- _____ - ________

Male _____ Female _____ Marital Status (circle): Single Married Divorced Widowed

Address ____
Apt. City State Zip Code

Phone Numbers: Hm _____ - _____ - ________ Wk _____ - _____ - ________ Cell _____ - _____ - ________

E-mail Address (for possible contact): ____

Employer ______________________________ Occupation ______________________________

Preferred Language (please circle): English Spanish Other

The following information is optional and is being gathered to ensure that all patients receive the best care possible.

Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic
- ☐ Native Hawaiian / Other Pacific Island
- ☐ White
- ☐ Other

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Native Hawaiian / Other Pacific Island
- ☐ Not Hispanic or Latino
- ☐ Other

Communication Preference (please circle): Email Postal Telephone

* Do we have your permission to contact you by texting? (please circle) YES NO

Primary Care Physician:

Name ______________________________

Address ______________________________

____

Telephone ______________________________

Other Specialist / Physician:

Name ______________________________

Address ______________________________

____

Telephone ______________________________

Guarantor (Person Responsible for Insurance / Billing) Information

Guarantor's Name ____
First Middle Last Preferred Name

Date of Birth _____/_____/__________ Social Security Number _____- _____ - ________

Relationship to Patient ____

Insurance Information

(Please fill out as completely as possible.)

Primary Vision Insurance (please circle): VSP VCP SPECTRA EYEMED OTHER: _________________

Policy Holder's Name ____

Policy Holder's Social Security Number _____ - _____ - ________

Medical Insurance: ____

Policy Holder Name ____

Policy Holder D.O.B. _____/_____/__________ Policy Holder SSN _____ - _____ - ________

Policy # _________________________________ Group # _____________________________________

Co-Pay $_____________ Deductible $ _____________

Policy Holder's Employer ____

Relationship to Patient __________________ Eligibility Date __________________

Please list other family members living at home who have not had a recent eye exam:

____

How did you hear about this practice? ____

Financial Policies (Insured and Non-Insured)

All service fees and co-payments are due when services are rendered. We will file claims for services rendered to the appropriate insurance payer in good faith. All medical eye care is subject to any insurance deductible. It is the patient's responsibility to know the specifics of the insurance plan and to pay any amounts applied to the patient deductible. Any unpaid balances that are left after 90 days will be subject to a monthly $5.00 late fee and additional service fee of up to 35% of your balance, if sent to collections. A minimum of 50% DOWN PAYMENT is required on all materials to start your order. Any balance will be due upon the dispensing of your eyewear. NO CASH REFUNDS ON MATERIALS.

CONTACT LENSES are medical devices requiring additional evaluation to ensure proper eye health, vision, and comfort. The fee for these services is not included in other eye care provided and varies with the contact lens type and complexity of the professional service. This fee **starts** at $84 and is most often not fully covered with vision insurance or other insurance plans. Fees for professional services are due in full on the service date and contact lens materials require a minimum 50% deposit to order. No contact lens prescription can be released until the lenses are finalized, which may require a mandatory follow-up visit. Please ask for any clarification needed about the policy on contact lens materials or services.

Insurance Authorization

I have read and understand the above policies and authorize payment of insurance benefits from Medicare, Medigap, or other insurance companies to be made on my behalf for any optometric services rendered. I also authorize Allisonville Eye Care Center, Inc. to release any information needed to the appropriate agency to determine any benefits and provide appropriate care.

***SIGNATURE (RESPONSIBLE PARTY)* ____ *DATE* _____/_____/___**

***Printed name of Responsible Party*____**

Notice of Privacy Policy

By signing below, I indicate that I have received a copy of the Notice of Privacy Practices of Allisonville Eye Care Center, Inc. (This can be printed in advance from our website, www.all-eyes.org, or obtained upon arrival.)

SIGNATURE (RESPONSIBLE PARTY) ____ DATE _____/_____/___

Allisonville Eye Care Center, Inc.

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