Patient Name: ___________________________ **Date of Birth:______________**

CONTACT AUTHORIZATION INFORMATION

Acceptable method of contact:

Home Phone # ______________________________ Cell Phone # ____

Work Phone # ______________________________ Alternate Phone # __________________________________

Email address _______________________________ May we email you? _____ Yes _____ No

May we text you with appointment reminders? _____ Yes _____ No

May we leave a message at your home or on your cell phone regarding appointments, test results, follow up care and/or billing matters? …… { } Yes { } No

May we call you at work? ……………………………………………………………………………………………… { } Yes { } No

Please list name(s) of person(s) we may release information to regarding your health care.

____

Name Relationship Phone #

____

Name Relationship Phone #

Professional Family Eyecare Financial Information: We will gladly file your claims with all insurance companies. Unfortunately not all vision/medical services are covered or paid by the insurance company, including those which might be helpful to the patient. Often payments are limited by the terms of your contract. In cases where the services have not been paid, you will personally be responsible for the bill. Laws require that we submit every claim accurately, reporting the exact services performed and the exact reason for performing them. While your insurance card no longer shows your social security number, it is still required for claim processing purposes.

If you have no insurance, or prefer to submit your bills yourself, we require payment in full at the time of service. We accept cash, credit cards and care credit.

RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT: This form allows Professional Family Eyecare to use and disclose information about me which is protected under the Health Insurance Portability and Accountability Act of 1996. This information will only be used to carry out treatment, payment or health care operations.

Professional Family Eyecare has provided me with the Notice of Privacy Practices, with more completely describes such uses and disclosures, prior to my signing this form, in accordance with my right to review its practice. I understand that the terms of the Notice of Privacy Practices may be changed and that I may obtain revised notices by contacting this office. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I authorize Professional Family Eyecare to submit a claim to my insurance carrier, Medicare or Medicaid for payment and I assign the benefits payable to them for services rendered. For and in consideration of any services rendered by Professional Family Eyecare, I hereby guarantee payment for any and all charges incurred for this account.

AUTHORIZATION FOR TREATMENT: The patient or his/her representative recognizing the need for the health care, consents to Professional Family Eyecare rendering services as ordered, including vision, medical, surgical treatment or other services rendered under the general specific instructions of the physician.

YOUR SIGNATURE ACKNOWLEDGES THAT YOU HAVE READ THIS INFORMATION:

Signature____ Date_________________________

Information on this page has been verified in OfficeMate Staff's Initials/Date _________________________