PATIENT INFORMATION

Thank you for choosing our office. In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date _____ Patient Name _____ Cell Phone _____
SSN _____ Male ___ Female ___ Birthdate _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Email _____
Check Appropriate Description: ___ Minor ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated
Patient's or Parent's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship to Patient _____
Address _____ Home Phone _____
Employer _____ Work Phone _____

INSURANCE INFORMATION - PRIMARY

Name of Insurer _____ Relationship to Patient _____
Birthdate _____ Social Security Number _____ Date Employed _____
Name of Employer _____ Work Phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local # _____
Ins. Co. Address _____ City _____ State _____ Zip _____
How Much is your deductible? _____ How much have you used? _____ Max. Annual Benefit? _____
DO YOU HAVE ANY ADDITIONAL INSURANCE - SECONDARY? ___YES ___NO If Yes, Name _____

INSURANCE OFFICE SUBMISSION

The following information pertaining to my medical/vision services/materials provided by Price Family Eye Care Professionals Inc. has been fully explained to me.

1. The patient/guarantor is ultimately responsible for any portion or all of the bill not covered by the Insurance company or vision/medical plan for any reason.
2. I understand that some service or materials are non-covered but agree to pay the additional charges.
3. I understand that Insurance quotes on eligibility or coverage amounts (full, partial or non-covered) cannot be guaranteed.
4. I do not hold Price Family Eye Care Professionals, Inc. responsible in any way for denial on payment (full or partial) on any claims submitted.
5. I understand that the guarantor is responsible for any unpaid portion of the bill, and agree to pay the balance in full.

I agree to all of the stated terms.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for Insurance benefits. I also hereby authorize payment of Insurance benefits otherwise payable to me directly to the doctor.

I authorize the release of any information pertinent to my case to any third party company, adjuster, physician or attorney involved in this case.

_____ _____
Signature of Patient or Parent if Minor Date

Witness: _____

If you fail to show for your assigned appointment without canceling 24 hours in advance you may be subject to a no-show fee of $20.00. If you fail to show for three visits, we may no longer be able to provide care to you.

Should you need non-medical forms completed (disability forms, mail-in prescription forms, application forms, school forms,) there will be a minimum charge of $15.00 payable in advance. Advance fees may be assessed if the physician is required to dictate multiple letters or if an extensive chart review is required.

- You will be provided, upon request, one copy of your glasses prescription and one copy of your contact lens prescription (provided all balances are paid in full and all required testing has been completed) at no additional cost to you. For each additional request a fee of $15.00 will be assessed.

- Although we will try to complete all forms in a timely manner, we may require 30 days advance notice for completion of some forms and chart reviews; this is within the guidelines set for by HIPPA.

Payment in full is required at time of order for all glasses and contact lenses. We accept credit cards, cash and personal checks.

- All sales are final. No refunds. All products come with a limited warranty including your prescription. If you have concerns regarding your glasses or contact lenses please call our office to schedule an appointment with one of our specialist. We will be happy to discuss and resolve and concerns you may have.

Our office has a guaranteed contact lens success program.

- Applies only to contact lenses purchased and fit within our office.
- Does not apply if your insurance dictates another policy.
- Applies only to fits that have not been finalized. Once final products are ordered and dispensed the products can not be returned.
- No cash refunds, a credit will be made to your account for any payment made toward the contact lens materials.
- All fitting and professional fees are final.
- Credit will be required to be used before the end of the year. (December exceptions only.)

By signing below you are agreeing to the following:

- The patient/guarantor is ultimately responsible for any portion or the entire bill not covered by the Insurance Company.
- You understand that some services or materials are non-covered but agree to pay the additional charges.
- You understand information obtained from your insurance carrier regarding co-payments, co-insurances, and deductible cannot be guaranteed.
- You do not hold PRICE FAMILY EYE CARE PROFESSIONAL, INC. responsible in any way for denial on payment (full or partial) on any claims submitted.
- You authorize release of any information concerning myself (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for Insurance benefits.
- You hereby authorize payment of Insurance benefits otherwise payable to me directly to PRICE FAMILY EYE CARE PROFESSIONALS, INC.
- You authorize the release of any information pertinent to your case to any third party company, adjuster, physician or attorney involved in this case.
- **You have read, understand, and have received a copy of PRICE FAMILY EYE CARE PROFESSIONALS, INC'S Notice of Privacy Practice.**

Date _____

Patient Name _____

Signature _____

14 _____ 15 _____ 16 _____ 17 _____ 18 _____ 19 _____ 20 _____ 21 _____ 22 _____ 23 _____