Family Eye Clinic

Sarah K. Storrs, O.D.

PATIENT INFORMATION

Date _____

Patient's Name (First, Middle, Last)_____ Gender:□ M □ F

Mailing Address_____ City, State, Zip_____

Home Phone_____ Cell Phone_____ Work Phone_____

(Circle one) Married Single Fulltime Student Divorced Widowed

Email Address_____

If 18 or older:
Driver License # _____State___ Expired____

SS#_____ Birth Date_____

Your Employer_____ Phone _____ Occupation _____

Spouse Name Spouse Employer Phone

Parent or Responsible party's information if NOT 18 years or older

Parent _____ Address_____ Work Phone _____

SS#_____ Birth Date__/___/___Drivers License #_____ State__ Expired____

Emergency Contact not living with you _____ Phone _____

How are you related to emergency contact? Business Friend Parent Relative *(please circle one)*

How did you hear about our office? □ Yellow Pages □ Doctor □ Walk-In

□ Friend (if so, who?)_____

Doctor Use Only

Reviewed by: Initials _____ Date _____
Initials _____ Date _____
Initials _____ Date _____
Initials Date

Publisher 3-2013

Family Eye Clinic Patient Policies

We truly appreciate you entrusting us with your eye health. We are a family, and we welcome you and your family. As an office and staff, we strive for excellence in eye care. But to do this, we need your help. To achieve this goal we have outlined specific appointment and financial policies. It is important that you know and understand these so we can serve you and all our patients to the best of our ability.

Appointment Policy **Initials:_____**

An appointment in our office is reserved specifically for you and the doctor. To give full attention to you, we do not "double book" our schedule. We also leave room in our schedule for "emergency" patients who have urgent needs. Leaving this open space will create minimal impact on patients who have reserved an appointment.

If you are unable to make your reserved time, we ask you call our office at least 24 hours in advance. A "no-show" appointment is when a patient fails to come in and does not call our office or leave a message in accordance with the previous guideline.

On the first no-show appointment, you will receive a written reminder of our policy. On the second no-show, you will be charged a missed appointment fee of $30. This fee must be paid before another appointment will be scheduled. After three no-show appointments, you and your family may be dismissed from the practice.

If you are running late for an appointment, we ask that you call us to keep us informed. This allows our schedule to flow as smoothly as possible. We will do all we can to adjust our schedule to get you in for service. Our patient coordinator will work with you as needed.

HIPAA **Initials:_____**

Family Eye Clinic will conform to all regulations protecting the integrity and privacy of your medical information by following the Health Insurance Portability and Accountability Act of 1996 (HIPAA). By signing below, you are acknowledging that you have been offered a copy of the "Notice of Privacy Practices." If you wish to have a copy of our Notice of Privacy Practices, please request one to take with you.

Financial Policy **Initials:_____**

Payment for professional services is due on the day of service. There is a 20% time of service discount for payment in full on the day of service. This applies to professional fees only (contact lens services and all materials are excluded). For glasses, we require a deposit of 50% of the total to place the order. The remaining balance is due when the glasses are picked up. For contact lenses, payment is due on pick-up. Contacts must be picked up within 90 days of ordering. If for some reason you cancel the order or do not return to pick up the product, there is a $2.00 restocking fee per box.

We will gladly check eligibility and submit your insurance claims to your insurance company as a courtesy to you. Statement of Benefits is quoted by your insurance provider, but is not a guarantee of payment. Your insurance policy is a contract between you, your employer, and your insurance company. It is the responsibility of the patient to notify this office of any changes to name, address, phone number and employer. If insurance has changed, it is the responsibility of the patient to present the new insurance card and information at the time of visit. ***Payment is required at the time of service for charges not covered by your insurance company including co-pays.***

I agree that I will be responsible to pay for any portion of the charges not covered by my insurance. If I fail to pay the outstanding balance within 30 days of the due date, I understand that my obligation may be referred to a third-party collection agency and that I will be responsible for any collection fees, interest, and other expenses necessary to collect on my account, including court costs, should legal action be instituted against me. I authorize Family Eye Clinic or any collection agencies used by Family Eye Clinic to contact me by my cellular telephone for billing activities or payment arrangements.

Assignment & Release **Initials:_____**

I hereby authorize payment directly to Family Eye Clinic for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurances, and for all services rendered on my behalf or on my dependent's behalf. I authorize Family Eye Clinic to release any information required to securer the payment of benefits. I authorize the use my signature below on all insurance submissions.

I have read, understand and agree to the above policies.

_____ _____ _____

Patient Signature (or legal guardian) Printed Name Date