Welcome back to our office!

We will need to get some information updated for our records. Please fill out the following.

Patient Demographics:

First Name (Legal) MI Last Name Preferred Name

Mailing Address City State Zip Code

Cell Phone Home Phone Daytime Phone

E-Mail Address Date of Birth Social Security Number

Employer Occupation

Marital Status: Single Married Divorced Widowed

Emergency Contact Information:

Name Relationship Phone

ACKNOWLEDGEMENT OF PRIVACY PRACTICES (HIPAA):

I have been presented with a copy of the Notice of Privacy Practices for Protected Health Information, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

I acknowledge that I have reviewed and understand these policies provided to me by Amarillo Family Eyecare.

Print patient name: _____Today's date_____

Patient signature (or parent/guardian if under 18): _____

AUTHORIZATION FOR RELEASE OF INFORMATION: Check here if you would like to give parent/guardian, spouse and/or other person(s) access to your information. (Please be advised if you were previously seen as a minor and are now of legal age, we will now need your consent on file for parental access.)

☐ I do wish to allow the following person, or persons, listed below disclosure of my health information:

_____

MEDICAL HISTORY & MEDICATIONS:

Do you currently wear any correction (glasses or contacts)? YES NO

Explain: _____

Do you have allergies to any medications, latex, etc.? YES NO

Explain: _____

Are you pregnant or nursing? YES NO

List any medication(s) you currently take. (Include prescription, over the counter, home remedies, etc.):

_____

_____

List any underlining conditions, such as any recent diagnosis, major surgeries, hospitalizations, etc.

_____

_____

INSURANCE:

I have provided Amarillo Family Eyecare with my updated insurance cards/information and hereby authorize payment of my vision & medical insurance benefits. I agree & understand I am financially and fully responsible for payment and any charges, whether paid for or denied, by my insurance. I understand that co-pays and/or deductibles are designated by my insurance company, and I agree to pay them to Amarillo Family Eyecare on the date of service. I authorize Amarillo Family Eyecare to release any information required to process any & all claims for reimbursement on my behalf. A copy of the authorization may be used in place of the original.

FINANCIAL POLICY:

As a courtesy to our patients, we will bill your insurance for services rendered in our office for you. Please remember ***these are estimates*** based on the information your insurance company has provided to us and is not a guarantee of payment. Therefore, your out-of-pocket expense is subject to change after your insurance has paid their portion. All remaining balances are the responsibility of the patient or responsible party. You must provide the correct insurance information before or at the time of service, as we will not change the claim after it has been filed. Most insurance companies allow a minimum of 90 days to file a claim, and some up to 18 months. Any claims not paid by your insurance company within 90 days of us filing your claim will become the responsibility of the patient/guarantor***. It is your responsibility to ensure that we participate in your insurance company's network.*** You should verify this information by contacting your insurance company/representative, reviewing your provider list, or speaking with your HR department.

All sales are final. There will be no refunds on accessories, contact lenses, glasses, or services. Contacts may be exchanged within a year of purchase and a 10% restocking fee will be applied.

Please sign below that you have read and agree to the policies above.

Print patient name: _____ Today's date: _____

Patient signature (or parent/guardian if under 18): _____