Welcome to our office!

Reason for today's visit: _____

When was your last eye exam? _____

Patient Demographics

Please circle: Mr. Mrs. Ms. Miss Dr. Child Male Female

_____

First Name 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

Emergency Contact Information:

Name: _____ Relationship: _____

Phone Number: _____

Whom do we thank for referring you to our office? _____

If not referred by a patient, how did you hear about our office? _____

Social History

Preferred language: English Spanish

Race: (please circle) American Indian Alaska Native Asian Black or African American
Hispanic Native Hawaiian or Other Pacific Island White

Ethnicity: (please circle) Hispanic or Latino Native Hawaiian or other Pacific Island Non- Hispanic or Latino

Do you have any hobbies that require special glasses or contacts? _____

If we are filing insurance for you today, the following questions must be answered:

In order to file any insurance claims for you, we must copy **ALL** insurance cards and photo I.D. at the time of your visit.

Employment Status: Employed FT Employed PT Not Employed Student Retired
Marital Status: Single Married Divorced Widowed

Guarantor (Account Responsibility) if patient is a minor:

_____

Full Name Relationship to Patient

_____

Daytime Phone Number Social Security Number Date of Birth

Vision Insurance Name: _____
Medical Insurance Name: _____
Additional Insurance Name: _____
Policy Holder: _____Policy Holder's Date of Birth: _____
Policy Holder's Phone Number: _____Policy Holder's Social Security Number:_____

INSURANCE:

I hereby authorize payment of my vision, medical and surgical insurance benefits to Amarillo Family Eyecare. I agree/understand I am financially and fully responsible for payment and any charges, whether paid for or denied by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, 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 and all claims for reimbursement on my behalf. A copy of the authorization may be used in place of the original.

Signature:_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

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 Name:_____

Signature:_____ Date:_____

I wish to allow the following disclosure of my health information:

_____

Financial Policy

As a courtesy to our patients, we will bill your insurance for services rendered in our office. All co-pays, deductibles, and estimated "out of pocket" expenses are due in full at the time of service. 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 or reviewing your provider list.**

Payment is due at the time services or products are provided. We accept cash, check, and major credit cards. For products and or services over $200, we also accept CareCredit. CareCredit allows you to purchase products today and spread payments over 6 months. Applying for CareCredit only takes a few moments and there is no fee to apply. You may call, go online, or simply fill out a form in our office. Our Office Manager would be happy to assist you.

Cancellation Policy

Amarillo Family Eyecare is committed to providing all of our patients with exceptional care. As part of our continued effort to provide you with the best care and accommodate all appointment requests, we have implemented a cancellation policy. When a patient cancels an appointment without giving proper notice, it creates an unused appointment slot that could have been used for another patient. That time had been specifically reserved for you. Also, a patient who misses an appointment fails to receive necessary medical care.

Please call us **by 2:00 p.m. on the day prior** to your scheduled appointment to notify us of any changes or cancellations. To cancel a ***Monday*** appointment, please call our office **by 2:00 p.m. on *Friday*.** If prior notification is not given, you will be charged $45 for the missed appointment. We understand that special, unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Please sign that you have read, understand and agree to these policies above.

_____ _____

Patient Signature (Patient's Parent/Guardian if under 18) Date