Patient Information

Important Note: **DO NOT** send this information via email. Save this form to your computer, print it, and bring it to your exam.
Due to provisions of the Health Care Act of 2010 and other regulations, we are required to collect certain personal, race, ethnic, language, and health related information. All personal information is confidential and protected. Please provide all requested information.

Patient Name_____ Today's Date_____

Address_____ City_____ State_____ Zip_____

Home Phone _____ Work Phone _____ Cell Phone_____

Date of Birth _____ Sex ☐ M ☐ F Social Security Number_____

Email _____

Preferred Method of Contact *(Select all applicable preferences)* ☐ Email ☐ Standard Mail ☐ Telephone ☐ Text Message

Race/Ethnicity ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White **Preferred Language** *(Select One)* ☐ English ☐ Spanish ☐ Other

Employment Status ☐ Employed ☐ Full Time Student ☐ Part Time ☐ None

Employer _____ Marital Status ☐ Single ☐ Married ☐ Other

Primary Care Physician_____ Physician's phone #_____

Name and address of clinic_____ City_____ State_____ Zip_____

If patient is a minor: Mother's name _____ Father's name_____

Insurance Information

Name of **Vision Insurance** Company _____

Subscriber Name_____ Date of Birth_____

Subscriber ID#_____ Group ID#_____

Employer_____

Relationship to Patient_____

Name of **Medical Insurance** Company_____

Subscriber Name_____ Date of Birth_____

Subscriber ID#_____ Group ID#_____

Employer_____

Relationship to Patient_____

Responsible Party *(if other than patient)*

Name_____ Relationship to Patient_____

Address_____ City_____ State_____ Zip_____

****************PLEASE PRESENT ANY INSURANCE CARDS AND FORMS TO THE RECEPTIONIST****************

I authorize the release of any medical or other information to process my insurance claims. I also authorize payment of medical benefits toy doctor. It is my understanding that I am responsible to obtain any and all referrals that my insurance company requires for service performed by that doctor. I also understand that I am responsible for any charges not covered by my insurance.

Patient Name (please print) _____ Date_____

Patient Signature_____

Distinctive Eyewear, Inc. -1280 South Ninth Street - St. Clair, MI 48079 – 810.329.9725

HIPPA / CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PURPOSE OF CONSENT: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, healthcare operations, the uses and disclosures we may make and/or other important matters about your protected information. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent.

RIGHT TO REVOKE: You have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance on the Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this consent.

I have had full opportunity to read and consider the contents of this Consent form. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

_____ _____ _____

Please print and sign your name Date
Parent or guardian, if minor

FINANCIAL POLICY

Please initial each paragraph.

_____ Due to the many changes in insurance policies it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. We urge you to check with your insurance company prior to any treatment. It is your responsibility to know your individual coverage. Failure to comply with this suggestion could result in you being responsible for all costs incurred. Please remember that it is your obligation to provide our office with your current and correct insurance cards, to know your individual coverage and to always provide us with any updated information. Please remember your insurance policy is between you and your insurance company, not between the insurance company and this practice or doctor.

_____Our office will submit your claim to your insurance company as a courtesy to you. If your insurance company has not paid your account in full within 90 days, the balance will automatically be transferred to you. Please be aware that some of the services provided may be non-covered services and could be your responsibility. All patient balances past due 90 days will be reviewed by collections. All returned checks will be subject to a $25 fee.

_____ Co-payments for ALL insurances are to be made at the time of service. Our allowable forms of payment are cash, check, CareCredit, MasterCard and Visa. We cannot waive co-pays.

_____Your follow up appointment are essential to your care. 24 hour cancellation notice is required. Otherwise, we reserve the right to charge a $35 fee for missed appointments.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. I have read and I understand and agree to this financial policy.

_____ _____ _____

Please print and sign your name Date
Parent or guardian, if minor