

Name: First/Middle/Last		DOB: (mm/dd/yy)
Mailing Address/City/State/Zip:		
Sex (please circle) Male Female	Marital Status S M W D	Social Security Number:
Home Phone: ()	Cell Phone: ()	Email Address:
Employment/School Status (please Circle) Full time/Part time	Employer Name & Occupation:	
Employer Address/City/State/Zip:		Business Phone: ()
Nearest friend or relative to contact in an emergency?		Phone Number: ()
How did you hear about us? (please circle one) Newspaper Friend/relative (Name) Insurance Co (Name) Internet Phone Book Another Dr. (name)		
Primary Insurance:	Policy Holder:	DOB
Policy Number:	Group Number	SS#
Secondary Insurance:	Policy Holder:	DOB
Policy Number:	Group Number	SS#
Head of Household/Person responsible for payment (please put family member(s) under same person)		
Name: First/Middle/Last	SS#	DOB
Street Address/City/State/Zip:		Home Phone: ()
Occupation:	Employer:	Business Phone: ()
Is this a Worker's Compensation Claim? (please cir) Yes No		
Claim Number:	Contact Person:	Date Of Injury

I the undersigned, give permission to release information to third party carrier (s) and all physicians and Eye Health Professionals (for the purpose of cross-coverage and to establish medical care), and do assign all insurance benefits for treatment to be paid directly to the above named provider and request that this agreement remain on file with my new insurance carrier. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Eye Health Professionals for any services furnished to me by that facility. I authorize any holder of medical information about me to be released to CMS (formally HCFA) and its agents any information needed to determine these benefits payable for related services. I certify that a copy of this assignment shall be valid as the original. I have the right to review the Written Privacy Notice prior to signing this form. By signing this consent form, I am in agreement with the use and disclosure of my protected health information used for treatment, payment, and health care operations. I have the right to revoke this consent , in writing, except where disclosures have already been made in reliance on my prior consent. Agreement for Extension of Credit Missed Appointment Policy: In Accordance with the Federal Truth-In Lending Act which requires all doctors to give their patients information in connection with extension of credit, please be advised of the following policies which apply in this office. The responsible party agrees to:

1. Pay the doctor at the time of service for non-covered services.
2. That I agree to pay interest at the rate of 18% annually on all balances over 90 days from the original due date, plus court costs and reasonable attorney's fees, with or without suit, incurred in collection any past due balance, and a collection fee equal to 40% of the outstanding balance.
3. Pay the balance in full if my insurance company does not cover the entire balance of this account within 90 days from the date of service after which there will be 1 ½% charge per month on unpaid balance.
4. A \$20.00 fee will be charge on all returned checks.

The following situations will result in you being held responsible for payment regardless of your insurance contract (s):

1. If you provide inaccurate/incomplete insurance information.
2. If your plan requires a referral or pre-authorization and you do not secure one.
3. If your plan requires you to see an "in-network" physician and our doctor is not defined as such with your insurance carrier(s)

Signature: _____ Date: _____