EYE HEALTH PROFESSIONALS

Dr. L.F. DuClos, O.D.
Dr. Bernadette Lynch O.D.

PATIENT INFORMATION			
Name: First/Middle/Last			D.O.B. (mm/dd/yy)
Mailing Address/City/State/Zip:			
Identifies as: Male Female They/Them	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: ( )
EMERGENCY CONTACT INFORMATION: Name:	Phone Number:		
How did you hear about us? (Please circle) Internet Another Doctor (Name) Friend/Relative (Name) Insurance Co. (Name) Other:			

INSURANCE INFORMATION			
Primary Insurance:	Policy Holder:	Relationship:	D.O.B.
Policy Number:	Group Number:	Social Security Number:	
Secondary Insurance:	Policy Holder:	Relationship:	D.O.B.
Policy Number:	Group Number:	Social Security Number:	

Head of Household/ Person responsible for payment: (Please put family member(s) under same person)		
Name: First/Middle/Last	Social Security Number:	D.O.B.
Street Address/City/State/Zip:		Home Phone: ( )
Occupation:	Employer:	Business Phone: ( )

I understand that my insurance policy is a contract between my insurance company and myself and that Eye Health Professionals is not a party to that contract. I give permission to release any information about me to all third party carrier(s) and to CMS (formally HCFA) and its agents to determine benefits payable for services 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 have the right to review the "Notice of Privacy Practices" prior to signing this form. I am in agreement with the use and disclosure of my protected health information used for treatment, payment, and health operation. I have the right to revoke this consent, in writing, at any time I feel justified. 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, co-payments, co-insurance and any services not covered by my insurance.
2. Pay interest at the rate of 18% annually on all balances over 90 days from the original due date with a $2 minimum monthly charge, plus court costs and reasonable attorney's fees, with or without suit, incurred in collection any past due balance, and a collection fee up 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.
4. Pay a $75.00 "no show fee" for missed appointments if I fail to notify the office within 24 hrs of appointment.
5. Pay a $20.00 fee 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: ______________________