

Welcome to Our Office

Patient's Name (please print) _____

If a Child, Parent's Name _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail Address _____

Birth Date _____ M or F _____ SSN _____

Employer _____ Occupation _____

Spouse's Employer _____ Work Phone _____

Health Insurance Carrier _____ Policy # _____

Medicare/Medicaid _____ Policy # _____

How did you find out about our office? _____

In order for Preferred Eye Care, LLC to provide healthcare to me, I understand that certain regulations require written authorization from me. I will provide Preferred Eye Care, LLC with the following permissions and authorizations:

1. I authorize release of information to other health care providers who may be consulted in the provision of health care to me.
2. I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment and authorize payment of these benefits directly to Preferred Eye Care, LLC on my behalf. I authorize any holder of medical information about me to release to my insurance company and its agents to determine benefits payable.
3. There may be times when the doctor or staff members will need to contact me regarding appointments or other communications. In order to contact me, I authorize the following:

You may contact me on my: home phone _____ work phone _____ cell phone _____

You may leave me a message on my: home phone _____ work phone _____ cell phone _____

I authorize Preferred Eye Care, LLC to discuss my eye care with the following people: _____

By signing below, I acknowledge that I understand if my circumstances should change, I am responsible for contacting Preferred Eye Care, LLC to make changes to these authorizations. I am personally responsible for my billing, including any amount not covered by my insurance. Should my insurance not cover services rendered, I am responsible for covering any unpaid balance. I have also been given a copy of the Notice of Privacy Practices from Preferred Eye Care, LLC.

Signature _____

Date _____