

PATIENT INTAKE INFORMATION				Appt Date: _____ Appt Time: _____	
First and Last Name		Preferred Name:		Gender:	DOB
Home Phone #		Home Address			
Cell Phone #					
Email Address		Employer			
SSN (if ins. requires)		Occupation			
RESPONSIBLE PARTY (if patient is a minor)					
Parent/Guardian Full Name		Relationship to Patient			
Date of Birth		Primary Phone #			
Address		Email Address			
LIST ALL CURRENT MEDICATIONS AND DOSE (including over the counter and supplements):					
ALLERGIES					
PRIMARY CARE INFORMATION					
Physician Name		Phone #			
<input type="checkbox"/> By checking this box, I agree to have my records or diagnosis information shared with my physician.					
PHARMACY INFORMATION					
Pharmacy Name		Address			
Phone #					
STATEMENT OF FINANCIAL RESPONSIBILITY					
FOR CLINIC OFFICE USE ONLY:					
Today's Copayment(s): Routine \$_____ Refraction \$_____ Medical \$_____ Retinal Screening \$_____ (if applicable) Contact Fit \$_____ (if applicable)					
Final charges will be determined once your exam services are completed and any material purchases have been decided upon					
Please indicate your preferred payment method for today's date of service: Cash: _____ Check: _____ HSA/FSA Card: _____ Debit/Credit: _____					
<p>For my eyecare provider to service my account, or to collect any amounts I may owe, I agree that I may be contacted at any number or address I have provided above or during a previous encounter. I understand that my eye exam and any optional contact lens fitting copayments are due today, and glasses or contact lenses may not be dispensed if any remaining copayments/balances are unpaid. I also understand that fees for services are non-refundable and non-negotiable, and any prescription information, for glasses or contact lenses, will have a valid expiration date indicated per federal law. I furthermore agree to pay any collection expenses incurred to collect any amount I may owe due to non-payment. I understand that I am solely responsible for the cost of all non-covered items, as outlined in detail on my receipt which includes: the specific date of service, description of each procedure/service, and the amount I am responsible for paying out-of-pocket; I certify that I have been informed of all items and cost. I authorize the release of my information for my eyecare provider to file all insurance claims if they are a participating provider for my plan. However, there is no guarantee of benefit information and/or coverage and if my insurance denies payment for any claims submitted, I will be responsible for full payment and can contact my insurance company directly should there be a dispute. My eyecare provider can also supply me with an itemized statement which I may submit to my insurance carrier, should I need to submit for reimbursement. I understand that any follow-up appointments related to a contact lens evaluation are included for three months after the initial fitting and should there be any follow-up appointments required after the three months have passed, I am responsible to pay the professional service fee. Additionally, I know that any optional testing that I have verbally agreed to pay for, is my responsibility to do as such on the date of service. Should I receive a medical examination, I understand that my major medical insurance will be billed, and I will be responsible for any deductibles, coinsurance or copayments that may be due.</p> <p>• I have read and understand the Statement of Financial Responsibility</p>					
Signature of Patient (or Parent/Guardian) _____ Date _____					