PATIENT INFORMATION FORM
OPTICARE

PATIENT NAME: _____

CELL PHONE: _____ E-MAIL ADDRESS: _____

IF YOU ARE UNDER 18, PLEASE GIVE THE FOLLOWING INFORMATION:
PARENT/GUARDIAN:

NAME: _____ RELATIONSHIP TO PATIENT: _____

CELL NUMBER: _____ E-MAIL ADDRESS: _____

SOCIAL SECURITY NUMBER: _____-_____-_____

VISION INSURANCE DATA:

IF YOU HAVE INSURANCE THAT COVERS EYE EXAMS OR ANY MATERIALS YOU MAY RECEIVE FROM OUR OFFICE, WE ARE PLEASED TO HELP YOU RECEIVE YOUR MAXIMUM ALLOWABLE BENEFITS. PROVIDE US WITH YOUR INSURANCE ID CARD AT THIS TIME, AND WE WILL BE HAPPY TO HELP YOU PROCESS YOUR INSURANCE CLAIMS FOR REIMBURSEMENT.

WHILE THE FILING OF INSURANCE CLAIMS IS A COURTESY WE EXTEND TO OUR PATIENTS, ALL CHARGES ARE ULTIMATELY YOUR RESPONSIBILITY.

IF YOU HAVE NO INSURANCE ID CARD YOU ARE RESPONSIBLE TO PAY FOR YOUR SERVICES TODAY. PLEASE ASK IF YOU HAVE QUESTIONS ABOUT THE ABOVE INFORMATION. WE ARE HERE TO HELP YOU!

PAYMENT FOR ALL SERVICES IS DUE ON THE DATE OF SERVICE.
HOW WILL YOU BE PAYING FOR YOUR SERVICES AND/OR GOODS TODAY?
(PLEASE CIRCLE OPTION BELOW.)

PLEASE READ AND SIGN:

I AUTHORIZE AND REQUEST OPTOMETRIC TREATMENT/SERVICES AND APPLICABLE FOLLOW UP CARE FOR MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY FINANCIAL OBLIGATION INCURRED FOR THE OPTOMETRIC SERVICES/GOODS PROVIDED. I ALSO AGREE TO PAY IN FULL ALL OF MY ACCOUNT(S) WITH OPTICARE, AND IF I FAIL TO DO SO, I AGREE TO BE LIABLE TO OPTICARE FOR FINANCE CHARGES (AT THE RATE OF 18% PER ANNUM ON BALANCES DUE MORE THAN 30 DAYS), COURT COSTS, EXPENSES, REASONABLE ATTORNEY FEES, AND OTHER NECESSARY COSTS INCURRED TO ENFORCE PAYMENT OF ANY PART OF THE ABOVE DESCRIBED ACCOUNT(S). IN THE EVENT THAT OPTICARE USES A COLLECTION AGENCY TO SECURE PAYMENT OF MY ACCOUNT, I ACKNOWLEDGE THAT I COULD BE CHARGED A FEE UP TO THIRTY PERCENT (30%) OF THE ACCOUNT BALANCE AS A COST OF COLLECTION.

CIRCLE ONE

SIGNATURE_____ Relationship to Patient _____ DATE _____CASH*CHECK*CREDIT CARD

SIGNATURE_____ Relationship to Patient _____ DATE _____CASH*CHECK*CREDIT CARD

SIGNATURE_____ Relationship to Patient _____ DATE _____CASH*CHECK*CREDIT CARD

SIGNATURE_____ Relationship to Patient _____ DATE _____CASH*CHECK*CREDIT CARD

SIGNATURE_____ Relationship to Patient _____ DATE _____CASH*CHECK*CREDIT CARD

SIGNATURE_____ Relationship to Patient _____ DATE _____CASH*CHECK*CREDIT CARD

MEDICARE PATIENTS ONLY:
I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE AND/OR OTHER INSURANCE BENEFITS BE MADE ON MY BEHALF TO DR. STEVEN GANDER AND/OR DR. BRUCE STORHAUG AND/OR DR. DESTIN COLES AND/OR OPTICARE FOR ANY SERVICES FURNISHED ME BY THAT PROVIDER. I AUTHORIZE ANY HOLDER OF MEDICARE INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THOSE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS AUTHORIZATION IS IN EFFECT UNTIL I CHOOSE TO REVOKE IT.

SIGNATURE: _____ DATE: _____

ACKNOWLEDGEMENT OF RECEIPT:
I ACKNOWLEDGE THAT I RECEIVED A COPY OF STEVEN P. GANDER, OD, BRUCE A. STORHAUG, OD, AND DESTIN R. COLES, OD, NOTICE OF PRIVACY PRACTICES.

PATIENT NAME: _____ DATE: _____

SIGNATURE: _____