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. <u>PROVIDE US WITH YOUR INSURANCE ID CARD</u>, 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.

<u>IF YOU HAVE NO INSURANCE ID CARD YOU ARE RESPONSIBLE TO PAY FOR YOUR SERVICES THE DAY THEY ARE RECEIVED</u>. 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 TODAY FOR SERVICES AND/OR MATERIALS
NOT FILED TO INSURANCE?

PLEASE CIRCLE ONE: *CASH * CHECK * CREDIT CARD*

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 COURT COSTS, EXPENSES, REASONABLE ATTORNEY FEES, AND OTHER NECESSARY COSTS INCURRED TO OBTAIN 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 FORTY PERCENT (40%) OF THE ACCOUNT BALANCE AS A COST OF COLLECTION. I UNDERSTAND THAT THIS AGREEMENT TO PAY IS A LEGALLY BINDING DOCUMENT, AND THAT I AM OBLIGATED TO PAY FOR ANY AND ALL PRODUCTS AND SERVICES PROVIDED BY OPTICARE FOR **ONE FULL YEAR FROM THE DATE OF MY SIGNATURE BELOW**. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR PAYMENT FOR THE NEXT YEAR EVEN THOUGH I WILL NOT BE REQUIRED TO SIGN ANY ADDITIONAL DOCUMENTS WHEN I COME IN FOR FUTURE APPOINTMENTS DURING THE YEAR.

SIGNATURE____________________ Relationship to Patient ____________________ DATE __________

MEDICARE PATIENTS <u>ONLY</u>:
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: ____________________________
(PLEASE PRINT)
SIGNATURE: ____________________________