

SEE WELL EYECARE PATIENT INTAKE FORM

What is the main reason for your visit today? _____

Patient Name: _____ Preferred Phone: _____

Birthdate: ____/____/____ SSN: ____-____-____ Other Phone: _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____ Gender: _____

Guardian (if applicable) _____ Occupation: _____

How did you hear about us? _____ If referred, who may we thank? _____

Circle appropriate selection: Minor Single Married Divorced Widowed Separated

Race/Ethnicity: _____ Preferred Language: _____

Primary Care Physician/Office: _____ Date of last visit: _____

Pharmacy of Choice (including address): _____

Please Initial Each of the Following Sections:

_____ Payment Policy: By making an appointment at See Well Eyecare, you are agreeing to abide by all billing policies of our practice. Payment is required at the time services are rendered or materials are ordered. Quotes of insurance coverage are based on information from the insurance company and are not guaranteed. Although we will gladly bill insurance for you, the patient remains responsible for their charges even after the insurance has been billed. If payment has not been received from insurance after 60 days, the patient will be expected to pay See Well Eyecare directly.

_____ Financial Responsibility: I understand that I am personally responsible for payment of my account even if I have insurance. If it becomes necessary to use a collection agency for any amount owed on this or subsequent visits, the undersigned agrees to pay all costs and expenses including reasonable attorney's fees. Accounts assigned to collections may be charged a \$40 collections fee.

_____ Cancellation Fee: A cancellation charge of \$40 may be billed to you personally if you do not provide at least 24 hours' notice of a cancellation or change in your appointment date or time.

_____ No Show Fee: A no show charge of \$40 may be billed to you personally if you do not show for your scheduled appointment.

_____ I understand that three (3) repeated missed appointments or late cancellations may result in dismissal from the practice.

_____ Release of Information: I hereby authorize release of my information to my insurance company or to any health care professional or education professional when necessary for my health care billing. (This allows us to bill your insurance.)

_____ Privacy Policy: We respect our legal obligation to keep health information private. We are obligated by law to give you notice of our privacy practices. If you would like to receive a copy of our Notice of Privacy Practices, please request one from the receptionist today or at any time in the future. I understand that See Well Eyecare has a Notice of Privacy Practices available for my review if I wish. At the present time, I acknowledge that this notice has been offered and I accept the Notice of Privacy Practices.

_____ These policies will be enforced for both new patients and established patients. Our staff will be happy to answer any further questions regarding these policies.

Signed (Patient/Patient Representative): _____ Date: _____

Description of Representative's Authority: _____