

SEE WELL EYECARE PATIENT INTAKE FORM

1. Reason for Visit & Patient Information

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? _____

Marital Status (circle): Minor Single Married Divorced Widowed Separated

Race/Ethnicity: _____ Preferred Language: _____

Primary Care Physician/Office: _____ Date of Last Visit: _____

Pharmacy of Choice (including address): _____

2. Practice Policies (Please Initial Each Section)

_____ **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.

_____ **Repeated Missed Appointments:** 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: _____

LET'S HELP YOU SEE YOUR BEST

GLASSES | SUNGLASSES | CONTACT LENSES

1. What do you currently use?

- | | |
|--|--|
| ☐ Glasses every day | ☐ Contact lenses |
| ☐ Glasses sometimes | ☐ Nothing right now |

2. What would you like help with today?

- | | |
|--|---|
| ☐ Everyday glasses | ☐ Computer glasses |
| ☐ Sunglasses - prescription or non-prescription | ☐ Contact lenses / annual supply |

3. What could we make easier for you?

- | | |
|---|---|
| ☐ Night driving or glare | ☐ Comfort or frame fit |
| ☐ Screens or reading | ☐ A backup or second pair |
| ☐ Sports or outdoor activities | ☐ An upcoming trip or special occasion |

4. What style would you like to explore?

- | | |
|---|--|
| ☐ Classic and simple | ☐ Bold or colorful |
| ☐ Modern | ☐ Please help me choose |

5. Would you like to see sunglasses today?

- ☐ Prescription ☐ Non-prescription ☐ Both ☐ Not today

6. Would you like us to review your benefits and savings today?

- ☐ Yes, please ☐ I have questions ☐ Not today

CONTACT LENS SAVINGS & CONVENIENCE

- Insurance benefits + eligible manufacturer rebates
- Help choosing the right contact lens solution
- Annual supply: free home shipping
- Smaller supply: home shipping available (shipping fee applies)

Thank you! Your answers help us make your visit easier and more personal.