MOSS EYECARE **WELCOME TO OUR OFFICE!**

Legal Name:_____Nickname (please call me):_____
Circle One: I am: Dr. Mr. Mrs. Ms. Miss Jr. Sr. I II III Circle One: I am: Married Single Widowed Domestic Partner Student
Address:_____Date of Birth: _____ / _____ / _____ Age:_____ Sex: M or Fe
City:_____Social Security Number: _____ / _____/_____
Home Phone: (_____) _____-_____ Your EMAIL is only used for in office professional purposes only,
Work Phone: (_____) _____-_____ such as: recall, confirming appointments, notification of eyewear
Cell Phone: (_____) _____-_____ ready. EMAIL:_____
Circle One: I am Employed Self Employed Retired Not Employed Student: School=_____
Patient's Employer:_____Patient's Occupation:_____

Our office uses SOLUTIONREACH to communicate with our patients via text messages.
Is it ok for us to text you to remind you of your appointments or to notify you when your eyewear is ready?
YES NO
YES, my cell #_____No, DO NOT text me, but CALL instead at:_____

WHAT IS THE PURPOSE OF TODAY'S VISIT?

_____Annual Eye Exam _____ Need GLASSES _____Need CONTACTS _____IOP Check _____Dry Eye Check
_____Eye Complication _____Glasses Recheck _____Contact Lens Recheck _____Glaucoma Monitoring

GUARANTOR INFORMATION

VISION INSURANCE

Vision Plan Name:_____
Name of Insured:_____DOB___/____/___
Name of Insured's Employer:_____
Relation to Patient: Self Spouse Child Student Other
Policy Holder's Social Security #:_____/_____/_____
Occupation:_____

MEDICAL / HEALTH INSURANCE CARD INFO.

This office is a medical facility. Your medical insurance may often times cover advanced testing and treatment of the eyes. Diseases of the body can show up in the eyes. If the doctor determines the need for a medical diagnosis / or procedure is evident, fees accessed will be billed to your medical insurance. Any medical co-pays will be due same day as service.

MEDICAL INSURANCE
Medical Plan Name:_____
Name of Insured:_____DOB___/___/____
Name of Insured's Employer:_____
Relation to Patient: Self Spouse Child Student Other
INSURED'S ID #_____Group #_____
Policy Holder's Social Security #:_____/_____/_____

NOTICE OF PRIVACY PRACTICES (NPP)

The Federal Law requires that we make every effort to inform you, the patient, of your rights related to your personal health information. Please check only ONE below:
____Yes, I have read the NPP available at Moss Eyecare and I wish to continue my care.
____ No, I have not read this office's NPP, but was given the opportunity to read it and declined. I wish to continue my care.
___The NPP could not be read due to the emergent nature of the care or other reasons described below.
Comments:_____

RELEASE OF HEALTH INFORMATION TO FAMILY, FRIENDS, ETC.

Please check one below:
_____Yes, I authorize all persons listed below the ability to receive materials (**glasses or contacts**) in my absence and/or information on my behalf.
Name:_____Relationship:_____Date:_____
Name:_____Relationship:_____Date:_____
Name:_____Relationship:_____Date:_____

FINANCIAL ASSIGNMENT & RELEASE

*I, the undersigned, assign directly to Moss Eyecare all insurance benefits, if any, otherwise payable by me or to me for services rendered.
*I understand that I am financially responsible today for all fees. I also agree that I am financially responsible to pay any and all fees for services and materials not collected in full at the date of service or should my insurance or vision plan deny payment for services or materials rendered.
*I further understand that after 60 days from the date my services or claim is filed I agree to pay for any unpaid balances on my account as a result of denial in part of whole from my insurance carrier caused by: unmet deductibles, non covered materials or professional services, my negligence in fulfilling any paperwork, providing any required information requested by insurance carrier or uncollected fees on service day.
*If I fail to reimburse said fees in a timely manner with the above stated office and should the need arise, I agree to pay any and all collection fees, court costs and attorney fees.
*IF YOU DO NOT INFORM US YOU HAVE A VISION PLAN OR MEDICAL INSURANCE BEFORE SERVICES ARE RENDERED, WE WILL ASSUME NO COVERAGE EXISTS.
*I agree I am responsible to file my own claim if I discover I have vision or medical benefits after services or products are rendered.
*I agree this office (with NO EXCEPTIONS) will not back file claims, post authorize claims, or refund fees after services are rendered due to

_____NO, I do NOT authorize any persons the ability to receive any materials (**glasses or contacts**) or information on my behalf. I choose to receive my eyewear myself.	lack of notification of vision or medical benefits. X_____ ____/____/_____ Patient or Responsible Party Signature Date Signed