MOSS EYECARE **WELCOME TO OUR OFFICE!**

PATIENT INFORMATION

Legal Name:_____ **Nickname** (please call me):_____
Circle One: Dr. Mr. Mrs. Ms. Miss Jr. Sr. I II III **Circle One**: Married Single Widowed Student Other:_____
Address:_____ **Date of Birth**: _____ / _____ / _____ Age:_____ Sex: M or Fe
City:_____ **Zip Code**:_____ **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: Employed Self-Employed Retired Not Employed **Student: School**=_____
Patient's Employer:_____ **Patient's Occupation**:_____
Can our office text you regarding appointments and status of your eyewear orders? YES NO
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 FOR ROUTINE EYE EXAM APPT.

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:_____

EMERGENCY CONTACT:

Name:_____
Phone: (_____)_____
Relationship to Patient:_____

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 #:_____/_____/_____
PRIMARY CARE PHYSICIAN:_____
PREFERRED PHARMACY:_____

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 persons listed below to receive materials (glasses or contacts) in my absence **and/or any health information on my behalf.**

Name:_____Relationship:_____

Name:_____Relationship:_____

_____NO, I do NOT authorize any persons the ability to receive any materials (glasses or contacts) or health information on my behalf.

FINANCIAL ASSIGNMENT & RELEASE

I assign 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 date of services), I agree to pay for any unpaid balances as a result of denial 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, I agree to pay any and all collection fees, court costs and attorney fees.

***IF I FAIL TO INFORM THIS OFFICE THAT I HAVE VISION OR MEDICAL INSURANCE BEFORE SERVICES ARE RENDERED, THE OFFICE WILL ASSUME NO COVERAGE EXISTS.** If I discover I have vision or medical benefits **after** services or products are rendered, I understand I am responsible to file my own claim. I agree this office (with NO EXCEPTIONS) cannot back file claims, post authorize claims, or refund fees after services are rendered. **If I have MEDICAID**, I am required to inform this office at time of service to avoid FINES and INSURANCE FRAUD.

*I also understand I am subject to a $25 no-show fee for any missed scheduled appointments.

GLASSES ORDERS: I understand that ALL SALES ARE FINAL.

X_____ ____/____/_____
Patient or Responsible Party Signature Date Signed