MOSS EYECARE **WELCOME TO OUR OFFICE!**

PATIENT INFORMATION

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 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: I am Employed Self Employed Retired Not Employed **Student: School**=______________________
Patient's Employer:__________________________ **Patient's Occupation**:____________________________
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:______________

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: Area Code (_______)_________________________
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 all persons listed below the ability to receive materials (**glasses or contacts**) in my absence and/or information on my behalf.
Name:_________________Relationship:______________
Name:_________________Relationship:______________
Name:_________________Relationship:______________

_____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.

FINANCIAL ASSIGNMENT & RELEASE

*I 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, I agree to pay for any unpaid balances 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 this office, 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) will not back file claims, post authorize claims, or refund fees after services are rendered. **If I have MEDICAID**, I understand I am required to inform this office to avoid FINES and INSURANCE FRAUD. * I understand I am subject to a $25 no-show fee for scheduled appointments.
***GLASSES ORDERS: I understand that ALL SALES ARE FINAL.**

X________________________________ ____/____/_____

Patient or Responsible Party Signature Date Signed