WELCOME

Patient Information

Full Legal Name____ Date of Birth _____/_____/_____

Social Security #_______________________________________

Mailing Address ____ City_____________________ State_____ Zip__________

Home Phone ____ Preferred Contact #: ☐ Home ☐ Cell

Cell Phone ____ Can we contact you via text message? ☐ Yes ☐ No

Email____ Can we contact you via Email? ☐ Yes ☐ No

Additional Information

Employer/School____ Occupation/Current Grade____________________

Spouse_______________________________________ DOB___/___/___ Cell ____________________________________

Emergency Contact Name _______________________________ Phone # ___________________ Relationship___________

Guardian Information

Father's Name____ DOB ___/___/___

Employer____ Social Security #____ _____________________________

Mailing Address ____ City_____________________ State_____ Zip______

Mother's Name____ DOB ___/___/___

Employer____ Social Security # _________________________________

Mailing Address ____ City_____________________ State_____ Zip______

Who Carries Insurance

Name____ Employer___________________________ DOB ___/____/____

Authorization For Benefits and Medical Release and Acknowledgment of Privacy Practice

I authorize insurance payments directly to Eye Care of the Big Horns, LLC. I further authorize the release of any information necessary to process claims on my behalf. I understand and agree that I am financially responsible for any charges incurred by me or any family members regardless of insurance. I acknowledge that I have received a copy of Eye Care of the Big Horns, LLC Notice of Privacy Practices related to HIPAA.
I request the following people have access to my medical information :

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Signature of Responsible Party **____*Date*** **________________**

Eye Care of the Big Horns, LLC

Financial Protocol

- Payment is expected at time of service
- Divorced parents: We are not a party to the divorced agreement. Therefore, the responsible party is the parent who accompanies the child to our office.
- Half down on eyewear orders is due upon ordering and remaining balance at pick up of product, and Payment of Contacts are due at time of ordering.
- We file claims with most insurance companies provided we have current insurance information.
- Copays and deductibles are due at time of service.
- Following 90 days of nonpayment, past due accounts will be turned over to a collection agency.
- Returned checks are subject to a $25.00 NSF fee and applicable postage.
- Patients are responsible for any emergency fees incurred, even if the insurance does not cover.
- Previous collections or NSF check: Any future appointments require the balance be PIF ath the time of the exam and/or materials' purchase with cash or credit card.

I, ______________________________________ , hereby acknowledge that I have read, understand, and agree to all of the terms and conditions listed above.

Signature: ____

Date: _____________________________________