PATIENT INTAKE INFORMATION

First and Last Name	Preferred Name:	Gender:	DOB
Home Phone #	Home Address		
Cell Phone #			
Email Address	Employer		
SSN (if ins. requires)	Occupation		

RESPONSIBLE PARTY (if patient is a minor)

Parent/Guardian Full Name	Relationship to Patient
Date of Birth	Primary Phone #
Address	Email Address

LIST ALL CURRENT MEDICATIONS AND DOSE (including over the counter and supplements):

ALLERGIES

PRIMARY CARE INFORMATION

Physician Name	Phone #

☐ **By checking this box, I agree to have my records or diagnosis information shared with my physician.**

PHARMACY INFORMATION

Pharmacy Name	Address
Phone #	

STATEMENT OF FINANCIAL RESPONSIBILITY

FOR CLINIC OFFICE USE ONLY:
Today's Copayment(s): Routine $_____ Refraction $_____ Medical $_____ Retinal Screening $_____ (if applicable) Contact Fit $_____ (if applicable)

Final charges will be determined once your exam services are completed and any material purchases have been decided upon

Please indicate your preferred payment method for today's date of service: Cash: _____Check: _____ HSA/FSA Card: _____ Debit/Credit: _____

For my eyecare provider to service my account, or to collect any amounts I may owe, I agree that I may be contacted at any number or address I have provided above or during a previous encounter. I understand that my eye exam and any optional contact lens fitting copayments are due today, and glasses or contact lenses may not be dispensed if any remaining copayments/balances are unpaid. I also understand that fees for services are non-refundable and non-negotiable, and any prescription information, for glasses or contact lenses, will have a valid expiration date indicated per federal law. I furthermore agree to pay any collection expenses incurred to collect any amount I may owe due to non-payment. I understand that I am solely responsible for the cost of all non-covered items, as outlined in detail on my receipt which includes: the specific date of service, description of each procedure/service, and the amount I am responsible for paying out-of-pocket; I certify that I have been informed of all items and cost. I authorize the release of my information for my eyecare provider to file all insurance claims if they are a participating provider for my plan. However, there is no guarantee of benefit information and/or coverage and if my insurance denies payment for any claims submitted, I will be responsible for full payment and can contact my insurance company directly should there be a dispute. My eyecare provider can also supply me with an itemized statement which I may submit to my insurance carrier, should I need to submit for reimbursement. I understand that any follow-up appointments related to a contact lens evaluation are included for three months after the initial fitting and should there be any follow-up appointments required after the three months have passed, I am responsible to pay the professional service fee. Additionally, I know that any optional testing that I have verbally agreed to pay for, is my responsibility to do as such on the date of service. Should I receive a medical examination, I understand that my major medical insurance will be billed, and I will be responsible for any deductibles, coinsurance or copayments that may be due.

- **I have read and understand the Statement of Financial Responsibility**

Signature of Patient (or Parent/Guardian) _____ Date _____