PERSONAL CARE OPTOMETRY

Fourth-Generation Vision Care

Date: _____

Patient's last name _____ First name_____

Dr. / Mr. /Mrs. / Ms./ Miss

If Patient is a child, Parent's or Guardian's name_____

Date of birth_____ Social Security #_____

Address_____

City_____ State_____ Zip code_____

Cell #_____ Work #_____

Employer_____ Occupation_____

Date of last exam_____ with whom_____

Email_____@_____ Referred by _____

Please provide us with your medical health and vision care insurance cards for us to copy

Insurance: VSP ____ EYEMED _____ MES _____ SPECTERA _____ MEDICARE _____ Other_____

Primary member on insurance: _____

Date of birth_____ Last 4 of Social Security # _____ Member ID# _____

Reason for today's visit _____

Medications _____

You may want to provide us with a list of your medications for us to copy

Medication allergies _____ Primary doctor_____

We take pride in answering your questions and addressing your concerns. Please feel free to discuss with us anything regarding our office, staff and, most importantly, your eye care needs.

We are dedicated to providing you with the highest level of care. It is our hope that your experience is a positive and pleasant one. We appreciate your referrals and would like to extend the same level of care to your family, friends and colleagues.

INSURANCE AUTHORIZATION AND FINANCIAL RESPONSIBILITY

I understand that I am responsible for all charges for services that I receive from Personal Care Optometry, and that the patient responsibility portion after insurance is applied to my charges (including charges applied to my deductible and/or coinsurance) are due at the time of service. All insurance copayments are non-refundable.

_____

Responsible Party Signature Print Name Date

Patient Name: _____ Date of Birth: _____

I understand this practice's Notice of Privacy Practices written in plain language. A copy of this form is provided by request.
The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practices legal duties with respect to my protected health information. That includes the following:

- A Statement that this practice is required by law to maintain the privacy of protected health information.
- A Statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes, treatment, payment, and health operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the secretary of HHS, if I believe my privacy rights have been violated, and that no retaliatory action will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to requested restrictions.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practice and to make new provisions effective for all protected health information that it maintains. If changes occur, this practice will provide a revised Notice of Privacy Practices upon request.

- ***Due to the custom nature of eyewear and contact lenses; all sales are final. If there is an optical problem, we are happy to reconfigure the prescription for you. Any cancellation of eyewear or contact lens orders will constitute a 30% processing fee.***

Signature: _____ Date: _____

Relationship to patient (if signed by a representative of patient) _____
