

EXACT EYE CARE - Patient Information

(Except for initials and signature, please print)



First Name _____ Street Address _____
Middle Name _____
Last Name _____ City _____
Gender: Male Female State _____ Zip _____
Primary Phone (____) _____
Date Of Birth (MM/DD/YYYY) ____ / ____ / ____ Other Phone (____) _____

Responsible Party Name _____
 Relationship Spouse Parent Other _____

I don't wish to use e-mail or text for reminders.

Email Address _____
 Use For: Exam Reminder Order Notification Appointment Reminder

Text Phone # (____) _____ Cell Service _____
 Use For: Exam Reminder Order Notification Appointment Reminder (Verizon, Sprint, AT&T, etc)

We do not market e-mail or text information and will only use it for those items checked above

Privacy Notice Acknowledgement

By initialing below, I acknowledge that I have reviewed and was offered a copy of the privacy policy of this organization
Initials _____

I do not have insurance coverage. (Skip to signature at the bottom of the form)

Primary Insurance Secondary Insurance
Insurer Name _____ Insurer Name _____
Subscriber Name _____ Subscriber Name _____

Release of Information Authorization

By initialing below, I am authorizing this office to release any information necessary to process claims on my behalf.
Initials _____

Assignment of Benefits Authorization

By initialing below, I am authorizing payment of medical benefits to the provider of those services/materials furnished to me.
Initials _____

Acknowledgement of financial responsibility

Our office will assist you with pre-determination of benefits and estimated expenses for treatment. We will also furnish sufficient documentation to assist you in obtaining the benefits to which you are entitled. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the provider and is not a substitute for payment. The estimated amount not covered by your insurance is due at the time of service. Our estimates are subject to final approval by your insurance company; therefore, the amount due our office is subject to change as well. By signing below, I acknowledge that any amount due after insurance has paid or denied is my responsibility.

Signature: _____ Date: _____