Professional Eye Care, LLC
Welcome To Our Office

Welcome to Professional Eye Care, LLC. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name | MI | Last Name | Preferred Name

Street Address | City | State | Zip

Social Security Number | Date of Birth | Home Phone - Include Area Code | Day Phone

Email Address | Guardian | Person Responsible for Account

Emergency Contact | Emergency Phone | Employer

How were you referred to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient
☐ Insurance Listing ☐ Drive by ☐ Other ☐ Doctor

Who were you referred by?

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company | City | State | Zip

M ☐ F ☐ Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status
☐ Single ☐ Married ☐ Other
☐ Full Time Student ☐ Part Time Student ☐ Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company | City | State | Zip

M ☐ F ☐ Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Race

☐ American Indian Or Alaska Native ☐ Native Hawaiian Or Other Pacific Islander
☐ Asian ☐ White
☐ Black Or African American ☐ Declined To Specify
☐ Hispanic Or Latino

Other Race

Ethnicity ○ Hispanic Or Latino ○ Not Hispanic Or Latino ○ Declined To

Preferred Language ○ English ○ Chinese ○ Dutch; Flemish ○ French ○ German ○ Hindi

Height ft | in | cm/m ◉ ft in ○ cm ○ m **Weight** ◉ lbs ○ kg

Name:

Please Read:

Assignment and Release:

I, the undersigned certify that I (or my dependent) have insurance coverage and assign all insurance benefits, if any, to the doctor (Professional Eyecare, LLC). I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature below on all insurance claim submissions.

In order to control the cost of billing, we ask that the patient's portion is paid at the time the services are rendered. Most all insurances will be submitted by this office for primary and secondary claims. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and the final determination can only be made when the claim is processed by the carrier.

There will be a service charge on all returned checks.

Signature _____ Date _____

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name _____

Address of Primary Care Physician _____ City _____ State _____ Zip _____ Phone _____

REFERRING PHYSICIAN

Referring Physician and Clinic Name _____

Address of Referring Physician _____ City _____ State _____ Zip _____ Phone _____

Receipt of Notice of Privacy Policies & Consent Form:

In the course of providing service to you, we created, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you or to obtain payment for our services.

The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insures for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you and to obtain payment for our services. You also signify that you have received a copy of our ***Notice of Privacy Practices***. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

You have the right to ask us to restrict the uses of disclosures made for purposes of treatment or payment, but as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment and payment. I acknowledge that I have received the Notice of Privacy Practices from ProfessionalOpticians, Inc.

Signature _____ Date _____

If signing as a personal representative of the patient, describe the relationship to the patient.

Relationship to Patient _____ Print Name _____