Eye 2 Eye Vision Center Get Acquainted Form

Patient Information:

_____ ____ _____Male___ Female___ _____/_____/_____
First Name MI Last Name Today's Date

_____
Street Address City State Zip Code

_____ _____ _____ _____
Date of Birth Social Security # Home Phone Work Phone

_____ _____
Place of Employment Occupation

Would you like to receive appointment reminders and information via text message or email? Yes_____ No _____

_____ _____ _____
Email Address Cell Number

Patient's Status: Single _____ Married _____ Divorced _____Other _____ Employed _____ Not Employed _____Retired _____Student _____

Primary Insurance Information: **(We must have a current copy of your insurance card and all information must be filled out or your insurance will not be billed. If the insured is under 18, then we must have the guardian's information below.)

_____ _____ _____
Name of Medical Insurance Name of Vision Insurance Insured's Name

_____ _____ Patient's Relationship to Insured: Self____ Spouse____ Child____ Other____
Insured's Date of Birth Insured's SSN#

_____ _____ _____
Guardian's Name Same as Insured ☐ Guardian's Date of Birth Guardian's SSN#

If you have a Secondary Insurance please list it here _____ _____
Name of Insurance Insured's Name & Date of Birth

Patient Demographics (Please circle one from each category)

Preferred Language:
English
Spanish
Other

Race:
Native American
Asian
African American
Hispanic
Native Hawaiian
Pacific Islander
Caucasian
Refuse to Answer

Please List All Current Medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you currently wear glasses? _____Yes _____No

Do you currently wear contact lenses? _____Yes _____No

Brand_____ Daily 2 week Monthly RGP Other _____

If no, are you interested in trying contact lenses? _____Yes _____No

TO ALL CONTACT LENS PATIENTS NEW AND ESTABLISHED:

Your best healthy eyesight is our goal. If you are a contact lens patient, we will do two examinations: One for your general eye health and sight, and one for your contact lens corneal health to ensure your contact lens fits and feels comfortable. For your advantage, as we do for all our patients, we will perform these exams each year so we do not miss anything that may be important for your best eye health.

Responsibility Statement:

Your insurance is a method for you to receive reimbursement for fees you have paid Eye 2 Eye Vision Center, P.C., for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them and not with our office. It is your responsibility to pay in advance for the deductible, coinsurance, or any other balance not paid for by your insurance. We will assist you in receiving as much reimbursement as possible; however, you are responsible in advance for your bill.

Examination fees and all copayments are due at the time of service. All products must be paid in full before they are ordered.
Refunds will not be given on services, customized ophthalmic materials, or contact lenses. Non-adapt remakes will be remade at no charge. Upgrades will not be refunded.

Financial Responsibility:

By signing this statement you agree to be financially responsible for all charges. If an account goes unpaid, a finance charge of 1.50% per month is applied to balances 60 days past due. A fee up to 33.33% is added to accounts sent out to Collections. All returned NSF checks will be charged a service fee of $25.

Authorization to Release Medical Information:

I authorize Eye 2 Eye Vision Center, P.C. to release/request medical information on my behalf to/from any entity to assist in my medical care per my request. I also authorize my insurance carrier to make payment directly to Eye 2 Eye Vision Center ,P.C. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be as valid as the original.

HIPPA Acknowledgement (Copy Available in Lobby):

I acknowledge that I was provided the opportunity to receive/review a copy of the HIPPA Privacy Policy Notice.

_____ _____ _____

Patient or Guardian Signature **Relationship to Patient** **Date**