EXACT EYE CARE - Patient Information

(Except for initials and signature, please print)

First Name _____ Street Address _____

Middle Name _____

Last Name _____ City _____

State _____ Zip _____

Gender: ☐ Male ☐ Female 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 _____

(Verizon, Sprint, AT&T, etc)

Use For: ☐ Exam Reminder ☐ Order Notification ☐ Appointment Reminder

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 acknowlege 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

Insurer Name _____

Subscriber Name _____

Secondary Insurance

Insurer 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: _____