Patient Welcome Form

Last Name**:** _____ **First** Name**:**_____ ☐ Male ☐ Female _____

Date of Birth: _____ Social Security #(last four digits): _____

Street Address: _____

City: _____ State: _____ Zip code: _____

Mobile Phone #: _____ Home Phone #: _____

Work Phone#: _____ Email: _____

Occupation: _____ Employer: _____

Reason for visit?: vision exam medical eye exam glasses contact lenses

Do you currently wear glasses? Yes No Do you currently wear contact lenses? Yes No

Date of Last exam: _____ Soft RGP Hybrid Scleral

Emergency Contact Name: _____ Relationship:_____

Phone#: _____

Vision Plan: _____

Name of Primary Insured: _____

Primary Date of Birth: _____ Primary Social Security #: _____

Member ID #: _____ Group #: _____

Relationship to Insured: ☐ self ☐ spouse ☐ child ☐ other

Patient Status: ☐ Single ☐ Married ☐ Other ☐ student

Medical Insurance: _____

Name of Primary Insured: _____

Primary Date of Birth: _____ Primary Social Security #: _____

Member ID #: _____ Group #: _____

Relationship to Insured: ☐ self ☐ spouse ☐ child ☐ other

Billing Policy

- ***Vision insurance does not cover medical eye problems, just as most medical insurances do not pay for routine vision problems.***
- Vision insurance will cover routine evaluations of the eye health and vision. It helps to pay for eyeglasses or contact lenses.
- Medical insurance coverage applies when there is a medical diagnosis/condition of the eyes such as eye pain, dry eye, diabetic retinopathy, glaucoma, cataracts, eye infection, etc., and does not cover the refraction portion of getting a vision prescription.

I, hereby, authorize Galleria/Centre Park Eye Care to file my claim with the appropriate insurance based on the reason/result of my examination.

X Initial: _____

Office Policy:

- Co-Payments, Co-Insurance, Deductibles, Non-covered services and Items exceeding your insurance maximum are due at the time of service after processing.
- Patient is responsible for any amount not covered by insurance. Payment is due within 60 days from the time of service.
- There are NO REFUNDS on services and/or spectacle orders. If the patient is not satisfied with the glasses ordered, there is one time 'redo' at no cost to the patient within 60 days of the purchase date.
- Any previous balance must be paid off before any further service.
- All purchases must be paid in full before or at the time they are dispensed.
- All spectacle/contact lens orders require at least 50% deposit before the order is placed.
- All Warranty replacement orders will require Shipping and Handling Fee of $42.
- Any Orders not picked up within 6 months of purchase will be discarded and the deposit on the order will not be refunded.

X Initial_____

Acknowledgement:

I acknowledge that I have read and understood the Notice of Privacy Practice of Galleria/Centre Park Eye Care and if needed, can request a copy of the Notice of Privacy Practices.

X Sign :_____ (patient or guardian)

X Date : _____

If guardian signed, Name: _____

And Relationship to the patient: _____

Please fill out backside —>

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change or to update your signature/date, if so, you will be notified at your next visit. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. By signing this form, I understand that: Protected health information may be disclosed or used for treatment, payment, or healthcare operations. The practice reserves the right to restrict the use of the information and the right to change the privacy policy as allowed by law.The practice may condition receipt of treatment upon execution of this consent.

I. **HIPAA agreement:** See above.
II. **Medical Release Authorization:** If requested by patient or by patient's health care provider at another location, I, the patient, authorize my medical information to be disclosed to/from the requesting party.
III. **Electronic Records:** Through electronic health portal, messaging, email services.

Signature: _____ Date: _____