Rev. 9-2-2016

PATIENT INFORMATION

Welcome to MACHA FAMILY EYE CARE - We are happy to have you here !

Last Name: **First Name:** **Middle Initial:** **Sex:** ☐ Male ☐ Female

Title: **Suffix:**

Date of Birth:

Nickname:

Social Security Number:

Address Line 1:

Marital Status:

Address Line 2:

Employment Status: Full Time, Part Time, Retired, Not Employed

City:

Employer:

State: **Zip:**

Occupation:

Home Phone:

****Preferred Language:**

Daytime Phone:

****Race:** ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Hispanic ☐ Multiracial ☐ Native Hawaiian/Islander ☐ White

Cell Phone:

Email Address:

****Ethnicity:** ☐ Hispanic ☐ Not Hispanic ☐ Hawaiian/Islander

Emergency Contact: ______

Phone: ______ **Cell:** ______

****How would you like to be contacted?** ☐ Mail ☐ Home Phone ☐ Cell phone ☐ Text ☐ Email

Referred By: Phone Book ____ Insurance Co. ____ Drive By: ____ Family/Friend ___ OTHER ______

**We do need ALL four (4) fields filled out, please.

ACCOUNT RESPONSIBLE INFORMATION (the person responsible for payment of account, if different from above):		
Name:	Date of Birth:	SSN:
Address/City/State/Zip:		
Home Phone:	Work Phone:	Cell Phone:
Employer:	Sex: ☐ Male ☐ Female	Relationship:

VISION INSURANCE		
PRIMARY Company Name: VSP / VSP / Davis / EYEMED / SPECTERA or OTHER: ______		
Policy Holder Name:	SSN:	Date of Birth:
SECONDARY Company Name: VSP / VSP / Davis / EYEMED / SPECTERA or OTHER: ______		
Policy Holder Name:	SSN:	Date of Birth:

MEDICAL INSURANCE		
PRIMARY Company Name: Medicare / Medicaid / Anthem / Aetna / United Healthcare or OTHER: ______		
Policy Holder Name:	SSN:	Date of Birth:
Policy Number:	Group Number:	
SECONDARY Company Name: Medicare / Medicaid / Anthem / Aetna / United Healthcare or OTHER: ______		
Policy Holder Name:	SSN:	Date of Birth:
Policy Number:	Group Number:	

FINANCIAL POLICIES: Co-payments are fees not covered by your insurance are due upon date of service. We will file claims for services rendered to the appropriate insurance payer in good faith. All medical eyecare is subject to any insurance deductible. It is the patient's responsibility to know the specifics of the insurance plan and to pay any amounts applied to the patient's deductible and/or co-insurance and for noncovered items.. A minimum 50% down payment on custom and special order materials is required to start your order. Any balance will be due upon dispensing of your eyewear. Unpaid balances are subject to monthly late fees and additional service fees if sent to collections. NO cash refunds on materials. Cancelled orders and returns are subject to penalty fees of up to 50% of original invoice. Materials will be sent back **30 days** after notification they have been received by our office and any money paid will be forfeited.

INSURANCE AUTHORIZATION I have read and understood the above policies and authorize payment of insurance benefits from Medicare, Medigap or other insurance companies to be made on my behalf for any optometric services rendered to Fountain Square Eye Care. I also authorize Fountain Square Eye Care to release any information needed to the appropriate agency to determine any benefits and provide appropriate care

Signature of responsible Party: ______ **Date:** ______

Printed Name: ______

Notice of Privacy Policies: By signing below, I indicate that I have received or been offered a copy of Fountain Square Eye Care Notice of Privacy Practices.

Signature of responsible Party: ______ **Date:** ______

Printed Name: ______