PATIENT INFORMATION

Which office are you visiting?

First Name

Last Name

Middle Inital

Sex

Male

Female

Date of Birth

dd — mm — yyyy

Title

Suffix

Nickname

Martial Status

Address

City

State/Province

Zip/Postal Code

Employment Status

Employer

Occupation

**Preferred Langauage

Race

Ethnicity

Home Phone

Daytime Phone

Cell Phone

Email Address

MACHA EYE CARE

PATIENT INFORMATION

HOW WOULD YOU LIKE TO BE CONTACTED:

☐ Cell Phone ☐ Email ☐ Text ☐ Home Phone ☐ Mail

Emergency Contact ______ Phone ______ Cell ______

Referrred By:

☐ Family/ Friend ☐ Insurance Co. ☐ Internet ☐ Drive By ☐ Other

ACCOUNT RESPONSIBLE INFORMATION

(The person responsible for payment of account, **If different from above)**

Name ______ Date of Birth dd – mm – yyyy SSN ______

Relationship ______ Sex ☐ Male ☐ Female

Address ______ City ______

State/Province ______ Zip/Postal Code ______

Home Phone ______ Cell Phone ______

Employer ______ Work Phone ______

PATIENT INFORMATION

FINANCIAL POLICIES:

The doctors and staff of Macha Eye Care are committed to providing you with thorough, professional eye care. As such, our office will file all claims with the appropriate insurance company in good faith. Co-Payments anc fees for non-covered services are due upon date of service. All medical care is subject to insured's deductible and/or coinsurance as well as for any non-covered items. We prefer payment win full when ordering eyeglasses or contact lenses. However, a minimum deposit of 50% is required to initiate the order. The remaining balance is due at dispensing. Orders must be picked up within 30 days of being notified that the product is ready. Orders that are not picked up will be sent back to the lab and money will be forfeited. There will also be a $20 re-stocking fee. Canceled orders will be processed on a case by case basis. We do not issue cash refunds. When applicable, we will refund your credit card or issue a check. We do not keep credit card information on file, so we will need it again to issue refund. We will make every effort to issue a refund in a timely manner. If you need a referral from your primary care provider to see us, it is your responsibility to obtain the referral. A referral with authorization number is NOT a promise to pay. Please realize that your insurance coverage is a contract between you and your insurance company. Your insurance company may still deny services despite our best efforts. Unpaid charges remain your responsibility. Our office will provide as much information as possible before your appointment. Any Outstanding balance after 90 days from date of service may be referred to an outside collection agency. Those accounts are subject to collection fee of 45%, which will be added to the total balance due at the time of transfer. Patients with unpaid delinquent balances or those sent to collections may be required to pay for all future services in cash. If you are more than 15minutes late for your appointment, you will be marked as a NO SHOW and will require rescheduling of your appointment. In addition, failure to arrive on time will result in a $25 late fee. This fee will be assessed to any cancellations within 24 hours. Our office makes numerous efforts to confirm appointments days in advance. We understand that emergencies happen and will do our best to be accommodating. We are more than willing to work with patients that require special circumstances. Patients that show up on time for their appointments will take precedence. I have read the above polices and authorize payment of insurance benefits from Medicare, Medigap, or other insurance companies to be made on my behalf for any services rendered to Macha Family Eye Care, PC. I also authorize MachaFamily Eye Care, PC to release any necessary information to the appropriate agency to determine benefits, process claims and provide care.

Notice of Privacy Polices: By signing below, I indicate that I have received or been offered a copy of Macha Family Eye Care, PC, Notice of Privacy Practices.

Name of Responsible Party ______