

# WELCOME TO RICHLAND EYE CARE, PLC

## **PERSONAL INFORMATION:**

Patient Name: \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M F  
Street Address: \_\_\_\_\_  
City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Marital Status: S M D W Name of Spouse: \_\_\_\_\_ Full-time Student: Yes or No  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

## **RESPONSIBLE PARTY:**

Patient Name: \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M F  
Relationship to Patient: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## **PREFERRED METHOD OF CONTACT:**

**Home Phone:** \_\_\_\_\_

May we leave messages with a family member? Yes or No

May we leave messages on your answering machine? Yes or No

**Cell Phone:** \_\_\_\_\_

May we text you? Yes or No

**Work Phone:** \_\_\_\_\_ Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

May we leave messages at your work? Yes or No

**Email:** \_\_\_\_\_

**Please Circle your preferred method of contact:** Home Phone - Cell Phone - Work Phone - Email - Mail

## **INSURANCE AUTHORIZATION:**

- I fully understand that I am personally responsible for all fees for eye care services and/or optical products purchased at Richland Eye Care, PLC which are not covered by a vision plan, medical plan, medical insurance, Medicare or another third party insurance plan. I also understand that if I am ineligible for insurance benefits due to insurance plan denial of coverage that I am responsible for full payment to Richland Eye Care, PLC for rendered services and/or products. I hereby authorize my insurance benefits to be paid directly to Richland Eye Care, PLC.
- I grant Richland Eye Care, PLC the permission to release, upon my demand, my medical records to other healthcare providers or insurance companies to further enhance my eye care well-being & for billing purposes.
- By signing below, I give Richland Eye Care, PLC permission to bill my insurance for eye care services and/or products. This will serve as my record of a "Signature on File" that insurance companies require for claims processing.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:**

My signature verifies that I have received or was offered a copy of Richland Eye Care's Notice of Privacy Practices:

Name of Patient (Print): \_\_\_\_\_ Signature of Patient: \_\_\_\_\_

**If patient is a minor or an adult unable to sign this form:**

Signature of Patient Representative: \_\_\_\_\_

Relationship of Patient Representative to Patient \_\_\_\_\_ Date: \_\_\_\_\_