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: _____