Patient Information Form

Today's Date____/_____/_____

Patient's Name _____

Last First MI

Date of Birth ____/____/_____ **Gender** (circle) **Male** or **Female**

Address_____

Street Apt/Unit City State ZIP Code

Home Phone (____) _____ **Cell Phone** (____) _____ **Work Phone** (____)_____

Email Address_____

Parent/Guardian _____ **Phone** (___)_____

Address (if different from above)_____

Please list any medications or vitamins you take on a regular basis: _____

_____

Primary Care Physician's name _____

PCP's Medical Group and phone number _____

Circle your special interests or hobbies for a better assessment of your vision needs: skiing, boating, fishing, scuba diving, flying, golfing, hunting, shooting, hiking, stamps, sewing, needlework, carpentry, metal work, musical instruments, racket sports, reading, other (please specify):_____

_____

EYECARE FOR YOU, LLC, FINANCIAL POLICY

Professional fees for services are due upon completion of the examination or treatment. If special arrangements are necessary for materials, please discuss your special needs with the administrative assistant.

I understand that insurance may not pay for all charges and I understand that I am obligated to pay for all the charges not paid by insurance. I agree that interest will accrue at the rate of 2% per month on any account balance not paid within 60 days of the date of service and I also agree to pay reasonable attorney and/or collection agency fees if my account is turned over to an attorney/collection agency.

HIPAA PRIVACY

Acknowledgment of Privacy Notice

I understand that EyeCare for You, LLC, may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information, and/or type of products provided) to another party to permit EyeCare for You, LLC, to perform its administrative duties, provide me with eye care services and products, process my vision benefit claims, and communicate with me regarding vision care services provided by EyeCare for You, LLC,(for example, mailings of exam reminders or information about services/products provided by EyeCare for You, LLC).

I can be assured that EyeCare for You, LLC, does not sell my personal health information of any kind to a third party for such party's own use. I authorize EyeCare for You, LLC, to submit my vision benefit claims to my plan sponsor or health plan to receive reimbursement directly for the vision services and products that I have received from EyeCare for You, LLC.

Please sign below acknowledging you have read the Financial and Privacy statements from above:

_____ _____

Patient Signature or Patient's Legal Representative **Date**

EyeCare for You, LLC. Marc A. Provencher, O.D., M.S.
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