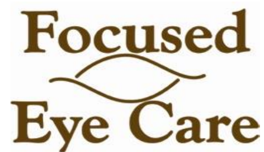

WELCOME!
Thank you for choosing Focused Eye Care for your eye health needs!
Please provide the following information. Please PRINT clearly.

Patient Name: ____________________ Birth Date:____________ Sex: M / F

Address:____________________City:____________State________Zip:__________

Home Phone:____________ Cell Phone:____________ Work Phone:____________

Social Security Number:____________ (if patient is OVER 18) Email: ____________________

Employer:____________________ Occupation:____________________

Marital Status: ________ Preferred Language:____________ Race:____________ Ethnicity: Hispanic/Latino or Non-Hispanic/Latino

Preferred Pharmacy:____________________ Phone:____________________

Primary Care Physician:____________________Phone:____________________

HOW DID YOU HEAR ABOUT FOCUSED EYE CARE? ____________________________________

****Communications, such as appointment reminders or order notifications, will be sent to you via your cell phone and/or e-mail address. If you do not wish to receive these notifications, you will have to unsubscribe or opt out via email or text. However, by opting out, you will not be notified when your contact or glasses orders are received.

Responsible Party Information: (example: self, minor child parent's info)

Name: ____________________ Birth Date: ____________ Sex: M / F

Address: ____________________City: ____________ State: ________Zip: ________

Home Phone: ____________Cell Phone:____________ Work Phone:____________

Email:____________________Social Security Number: ____________

Employer:____________________ Occupation:____________________

Insurance Company:____________________ID____________________Group____________

Name of Policy Holder:____________________ Policy Holder Birth Date:____________

Policy Holder Employer:____________________ Policy Holder Social Security Number:____________

Secondary Insurance Company____________________ ID____________________ Group____________

Name of Policy Holder:____________________ Policy Holder Birth Date:____________

I AGREE TO ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ANY AND ALL CHARGES NOT COVERED (OR DENIED) BY MY INSURANCE. I UNDERSTAND FOCUSED EYE CARE ESTIMATES WHAT MY INSURANCE WILL COVER AND THIS IS NOT A GUARANTEE OF BENEFITS. I will call my insurance if I have questions.

Signature:______________________________Date:____________________

FOCUSED EYE CARE PA Patient Authorization and Consent Form

Consent for Treatment: I consent to and authorize my health care provider to examine and treat me. I understand this could include lab tests or other diagnostic procedures, education, or photographs. I understand my provider is available to explain the purpose of the procedures and treatments, and I have the right to refuse such procedures or treatments.

- I authorize FEC to verbally communicate with me regarding my personal health care or billing information by leaving voicemail messages on phone number:___________________________

Privacy: I acknowledge I have received a copy or have been made aware of FEC's privacy practices. I understand I may request a copy of this privacy notice if I so desire. I authorize FEC to discuss and disclose the health care or billing information to others as provided below:

- I authorize FEC to verbally communicate regarding my personal health care or billing information with;
  Name:____Relationship:_____________________
- If applicable, I authorize FEC to correspond through email my personal health care or billing information with;
  Name:____Relationship:____________________

Assignment of Benefits and Release of Information: I request payment of authorized benefits directly to the provider for services and/or materials furnished to me at this practice or any other practice owned and operated by FEC. I consent to FEC releasing my health records and other information related to my health care services for payment and healthcare operations purposes. I agree that FEC may release my health records and other information to Medicare, my insurance company or other health maintenance organization, other payers, payer network organizations, including accountable care organizations, in which my providers participate, and the contractors and third party administrators of any of these parties.

Release of Information by Payers and Networks: I authorize Medicare, my insurance company or health maintenance organization, other payers, payer network organizations including accountable care organizations, and their contractors and third party administrators to share my health records and information obtained from FEC or any other provider, with FEC, other providers from whom I have received services, or any other payer, payer network organizations, including accountable care organizations, in which my provider participates, and the contractors and third party administrators of these parties as needed for payment and health care operations.

Release of Information to health Care Providers: I consent to the release of my health records created, received, and maintained by FEC for my treatment to other health care providers who are involved in my treatment.

Payment Agreement: I understand I am financially responsible and agree to pay promptly for any charges for the care rendered to me or my dependents not covered by my insurance plan or if I do not have active insurance coverage. Receiving a cancellation notice in advance allows us to schedule and service other patients. We reserve the right to bill you $25 for missed appointments without a 24-hour advance notice. This fee is not covered by insurance, or Medicare, and will be your responsibility to pay before your next visit.

Returning Materials: Focused Eye Care strives for excellence every time we create a pair of glasses or contacts. However, due to the customization of these medical products, they are not returnable nor refundable. Please bring any issues/concerns with these products to our attention immediately. I agree to a restocking fee of 50% of the order cost for any order I cancel or do not pick up.

Signature: ____ Date:____________________________