EYECARE VISION OPTOMETRY

Basic Information					
Check one:	□ Mr.	□ Mrs.	□ Ms.	□ Dr.	□ Other:___
Last Name:			First Name:		
Middle Initial:			Suffix:		
Nickname:					
Address:					
City:			State:	Zip Code:	
Cell Phone #:			Work #:		
Home Phone #:			E-mail:		
Other Phone #:					
Preferred Method of Contact: □ Cell # □ Home # □ Work # □ Other # □ E-mail Address					
Date of Birth:			Sex: □ Female □ Male		
Occupation:			Employer:		
If Student, please write the name of your school:					
Name of Guardian the contact information belongs to (if a minor):					
Primary Doctor: □ Dr. Simon Chen OD □ Dr. Ling Huang OD □ Dr. _____					
Reason for your visit today:					
How did you hear about us?					

Insurance Information	
□ None *If you have insurance, please proceed below and complete the information.	
Name of Insurance Company:	
ID# (or SSN if not assigned one):	
*If patient is not the primary subscriber, please fill out the following:	
Last Name of Subscriber:	First Name of Subscriber:
Date of Birth:	Relation to the Patient:
ID# (or SSN if not assigned one):	

*While we assist in filing your insurance on your behalf, we cannot guarantee coverage. As the insured, you are responsible for knowing your insurance benefits and requirements for coverage and ensuring that any necessary referrals or authorizations are obtained before receiving services. In the event of a dispute or rejection of a claim, you are responsible for that payment. We may require payment for your services in full at the time of your visit, if your insurance company cannot provide your copay and responsibility amount on the date of service, until after claims are reviewed or posted. Any insurance benefits that are later received for those services will be refunded to you.

I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I understand that I am financially responsible for all charges whether or not paid by my insurance company. Payment is due at the time services are rendered. There will be a $50 non-sufficient funds fee for returned checks. A finance charge of 2% per month will be charged for any balance over 30 days past due. All return policy is up to the office's discretion. If you have any questions regarding this, please ask office staff before orders are filled.

_____ _____

Signature Date

_____

Print Name (and relation if signed by guardian)

Notice of Privacy Practices (HIPAA Compliance):

I acknowledge that a copy of the EyeCare Vision Optometry Notice of Privacy Practices have been made available to me. *(If you would like a copy, please request at the front desk).*

_____ _____

Signature Date