John Day Eye Care - Welcome

Welcome to John Day Eye Care. Thank you for choosing us for your eye care needs. We are delighted to have you as a patient. Please take a moment to complete the following information.

[] Mr. [] Mrs. [] Ms.

____

First Name MI Last Name

____

Cell Phone Home Phone Work Phone

Preferred Phone [] Cell [] Home [] Work

Email Address ____

Person Responsible for Account (Sign at bottom) ____

[] Please check this box if you **do not** want email/text notifications for appointment reminders or notification that glasses or contacts have arrived.

What is the main reason for today's exam? ____

Are you planning to update your glasses today? []Yes [] No [] Undecided

How do you use your eyes (what are your hobbies, how much time do you spend on digital screens, etc.)

Insurance Information (Initial next to information if correct – make any corrections needed)

Primary Medical Insurance ____

Secondary Medical Insurance ______________________________________

Primary Vision Benefit Plan ____

Secondary Vision Benefit Plan ____

Please Read:

The patient's portion is to be paid at the time services are rendered unless other arrangements are made in advance. The undersigned will be responsible for any charges incurred in this office, regardless of insurance. Any over payments to this office over $20 will be refunded by check, any amounts under $20 will remain as a credit on the account unless requested as a refund. Accounts 120 days old are subject to collections. There will be a service charge on all returned checks of $15. **Professional services are not refundable**, and all product sales are final.

For patients with claims that will be billed to their medical insurance or vision benefit plan: Your insurance contract is between you and your insurance company, not between John Day Eye Care and the insurance company. Acceptance of insurance assignment by this office does not absolve you of your responsibility for the charges for the treatment rendered or products received. We can make no guarantees of the insurance payment. All benefits quoted to you are not a guarantee of payment by your insurance company, and that final determination can only be made when the insurance claim is processed. If your insurance does not pay for a procedure or products, or informs us that your co-payment is more than what we had initially charged you at the time of your visit, you are responsible for payment in full. If there are any discrepancies please contact your insurance company and/or employers benefit department.

I authorize payment from my insurance company to be paid directly to Eye Care of John Day, Inc. (DBA John Day Eye Care). I authorize the use of this form on all insurance submissions and the release of all information to my insurance companies. I permit a copy of this authorization to be used in place of the original.

____ ______________________

Signature Date

John Day Eye Care – Privacy Practices

Patient Name: ____

- I acknowledge that I have had the chance to review the Notice of Privacy Practices and upon request may have a copy.
- I give the staff of John Day Eye Care permission to leave messages on my voicemail or with members of my household.
- I give the staff of John Day Eye Care permission to discuss my health information/release my medical information to the following individuals:

Name:_______________________________ Relationship:______________ Phone Number:_______________

Name:_______________________________ Relationship:______________ Phone Number:_______________

Name:_______________________________ Relationship:______________ Phone Number:_______________

Name:_______________________________ Relationship:______________ Phone Number:_______________

[ ] None: Please do not disclose my health information to anyone.

____ ____________________________

Signature Date