PATIENT INFORMATION (Please Print)

Full Name _____ DOB ____/____/____Sex ☐M ☐F

Street Address _____ City: _____ State: _____ Zip_____

Mailing Address _____ City: _____State: _____Zip_____

Home Phone # _____Cell Phone # _____ Primary Phone # ☐ HOME ☐ CELL

Marital Status: Single Married Divorced Widowed E-mail Address_____

Parent/Guardian Name_____ Parent/Guardian DOB ____/____/____

Emergency Contact _____
NAME PHONE NUMBER RELATION TO PATIENT

Employer [Or School]_____ Occupation: _____

Is this your first visit to our office? Yes No Whom may we thank for referring you _____

Please list the Names of the Family Members in your home (kept confidential**) ~** *some vision problems are hereditary.*

Patient Here?	NAME	RELATION	DATE OF BIRTH	LAST EXAM
YES NO				
YES NO				
YES NO				

Insurance Information

Insurance Name: _____Insurance ID# _____

Responsible Party: _____
(if not patient) Name Relationship to Patient DOB Phone SSN

LIFETIME SIGNATURE ON FILE, AUTHORIZATION TO RELEASE INFORMATION/ ASSIGN BENEFITS

I hereby authorize and request S&S EyeCare, LLC to release any information obtained during the course of my evaluation and treatment which is necessary for the processing of insurance claims, disability statements, or documentation of services rendered. I hereby authorize and request payment of all applicable medical/vision insurance benefits for the services rendered by S&S EyeCare, LLC directly to S&S EyeCare, LLC. I understand and agree that I am responsible for all charges not paid in full by my health insurance carriers, including all applicable co-payments, deductibles and co-insurance amounts. I agree to pay all costs and reasonable fees in the event this account is turned over to a collection agency. I permit a copy of this authorization to be used in place of the original signature. This assignment shall remain in effect until revoked by me in writing.

ADVANCE BENEFICIARY NOTICE: I further understand that Medicare does not pay for a Refraction (code 92015); and Medicaid, Medicare and Tricare do not pay for contact lens fittings (code 92310).

CANCELLATION/NOSHOW POLICY: We understand that there are times that you must miss an appt due to emergencies or obligations. However, when you do not call to cancel an appt, you may be preventing another patient from getting much needed treatment. If an appt is not cancelled at least 24 hours in advance you may be charged a $25 fee; this fee will not be covered by your insurance company.

***Signature of Patient/Guardian**_____**Date**_____/_____/_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been offered or read a copy of the "Notice of Privacy Practices" from S&S Eye Care, LLC and agree to continue my care under said terms.

***Signature of Patient/Guardian**_____**Date**_____/_____/_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I understand that my medical records are protected under State and Federal confidentiality regulations. If our staff calls to *DISCUSS* your care, are there members of your household that we can *DISCUSS* your medical information or appointments with? □ **YES** □ **No**

If yes, please specify: Name: _____Relationship: _____

This authorization expires in: □ 1 year □ No Expiration □ Other (must specify)_____

***Signature of Patient/Guardian**_____ **Date** _____/_____/_____