



PATIENT INFORMATION

Patient Name _____
Address _____
City _____ State _____ Zip _____
SS# _____
EMAIL _____
Sex M F Age _____ Birthdate _____
Married Widowed Single Minor
Separated Divorced
Occupation _____
Patient Employer/School _____
Responsible Party Name _____
DOB _____ Relationship to patient _____
Whom may we thank for referring you?

PHONE NUMBERS

Home () _____
Cell () _____
Work () _____
Best place to reach you _____

Name of policy holder on insurance _____
Relationship to patient _____
Policy holder's employer _____
DOB _____ SS# _____

CONTACT LENS PATIENTS

Contact lenses are considered a medical device, therefore, the fit of the lens, health of your eye and prescription must be evaluated yearly. Additional tests and measurements are performed during your eye exam. Fees for this service are determined by the type of contact, prescription and whether this is a new or existing exam. I understand and agree to this service.

Initials _____ Date _____

AUTHORIZATIONS

PLEASE PROVIDE THE FRONT DESK WITH CURRENT INSURANCE CARDS FOR SUBMISSION OF SERVICES.

NO INSURANCE INFORMATION PROVIDED CHARGES WILL BE PATIENTS RESPONSIBILITY

ALL Insurance authorization and release

I certify that I have coverage and assign directly to Peak Eye Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Peak Eye Care may use my healthcare information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determine benefits or the benefits payable for related services.

****Medicare patients—Medicare does not cover refraction fees and I agree to pay for this service.**

I agree and been informed of the HIPPA Notice of Privacy Rights.

Signature (Patient,Parent, Guardian or Legal Representative) _____

Printed Name _____ Date _____

RETINAL IMAGING

Peak Eye Care doctors perform routine images of your eyes annually. Only if a medical condition exists will charges be submitted to your medical insurance. Some routine vision insurance plans offer this service with a co-pay. Our charge is \$40.00.