HORIZON EYE CARE PATIENT INFORMATION FORM - ***Please give your cards to the receptionist with completed form***

Patient's Name: _____ Date of Birth: _____
Male/Female

First Middle Init Last

Address:
_____Apt#_____City_____State_____Zip_____

Marital Status: _____Your Social Security #: _____Email Address:
_____

Best Telephone Number to reach you: _____ OK to leave a message:
YES NO

Who is your primary care physician: _____City:_____State_____
Did a physician refer you to us? _____ if yes, name of physician_____

Is today's appointment related to a work injury or and auto injury? _____Date of Injury?
_____

Who is your Vision Plan Carrier (Covers Exams for New Glasses):
_____

For example: VSP, Davis, Optum, Eyemed

#1 Primary Medical Insurance Co: _____POLICY#
_____

Group#_____
_____
Subscriber's Name Subscriber Date of Birth Subscriber SS#

#2 Secondary Medical Insurance Co: _____POLICY#
_____

Group#_____
_____
Subscriber's Name Subscriber's Date of Birth
Subscriber's SS#

Please share my health information with the people listed below. If no one is listed, under federal regulations, we are prohibited from speaking with anyone else concerning your care.

Person to Contact: _____Relationship:_____ Phone Number: (___)
_____
Person to Contact: _____Relationship_____ Phone Number: (___)
_____

AUTHORIZATIONS: - With your signature and date below you are hereby authorizing Horizon Eye Care, PA for the following:

a. I hereby authorize Horizon Eye Care and/or any of its employees to bill any and all of my insurance providers for services rendered to me by the physicians and/or staff of Horizon Eye Care.
b. I authorize the release of any of my personal health information so that benefits may be paid directly to Horizon Eye Care. This authorization remains effective until changed by the patient in writing.
c. To access & process my prescription and medicine information electronically.
d. If a referral is required by my insurance, I understand it is my responsibility to have it prior to my visit at Horizon Eye
e. I acknowledge that I have been directed to the Horizon Eye Care Notice of Privacy available in the office or can request a copy.
f. I acknowledge appointment reminders and other printed materials will be mailed to me unless I request electronic format.
g. I acknowledge that this authorization will remain in effect from the date of my below signature unless I change it.

h. I acknowledge that I am financially responsible for any and all charges related to my visit. Once my insurance company has replied to the claim, it is my responsibility to resolve any and all outstanding balances or issues with the insurance company.
i. I acknowledge that any applicable co-pay is due on date of service. If not paid, I will be charged an additional $10 service fee.
j. I acknowledge that I may submit a written request for a copy of my e-PHI.
k. I authorize Horizon Eye Care to send me marketing information relevant to the care of my eyes.
l. I acknowledge that any balance after 60 days is subject to late fees, interest and possibly court fees for which I am responsible.

Patient's Signature: _____ today's Date: _____