PATIENT INFORMATION

THIS FORM MUST BE UPDATED ANNUALLY OR AS SOON AS CHANGES OCCUR.

PLEASE PRINT

TODAY'S DATE	PATIENT'S NAME FIRST MIDDLE LAST	BIRTH DATE	AGE
GENDER	HOME PHONE	WORK PHONE	CELL PHONE
E-MAIL ADDRESS	BY PROVIDING MY E-MAIL ADDRESS, I CONSENT TO RECEIVE PERIODIC NEWSLETTERS, PROMOTIONS, AND EDUCATIONAL MATERIALS FROM CAPITAL EYE. WE DO NOT SELL E-MAIL ADDRESSES. YOU CAN "OPT-OUT" AT ANY TIME IN THE FUTURE		
STREET	APT NUMBER	CITY	STATE / ZIP
	MARITAL STATUS	OCCUPATION	
YOUR OPTOMETRIST	PHONE	FAX	
YOUR MEDICAL DOCTOR	PHONE	FAX	
PHARMACY	PHONE	STREET and TOWN	

RESPONSIBLE PARTY (if other than patient)

FIRST NAME MIDDLE LAST NAME		BIRTH DATE
STREET APT NUMBER	CITY / STATE	ZIP
PHONE	RELATIONSHIP	OCCUPATION

INSURANCE INFORMATION

PRIMARY

POLICY HOLDER'S NAME, FIRST MIDDLE LAST NAME		
RELATIONSHIP		BIRTH DATE
INSURANCE CARRIER	POLICY NUMBER	GROUP NUMBER

SECONDARY

POLICY HOLDER'S NAME, FIRST MIDDLE LAST NAME		
RELATIONSHIP		BIRTH DATE
INSURANCE CARRIER	POLICY NUMBER	GROUP NUMBER

EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY CONTACT (REQUIRED) NAME	RELATIONSHIP
PHONE NUMBERS	

CONTINUED ON BACK

AUTHORIZATION AND INSURANCE ASSIGNMENT

I hereby authorize Capital Eye Consultants to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company to be made to the above named provider. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any information to my insurance company in order to determine insurance benefits to which I may be entitled. I also authorize the release of my medical information to any physician or facility to which I am referred for diagnostic testing or other services necessary to my treatment. I may revoke this authorization at any time in writing.

CANCELLATION POLICY

Capital Eye Consultants is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen and, therefore, we do have a cancellation policy in effect. We greatly appreciate your consideration by notifying us as far in advance as possible, however, **you are required to give this office a minimum of one business day (24 hours not to include weekends or holidays) notice** prior to the scheduled appointment. Failure to comply with this office policy will result in a **$40 cancellation fee**, which must be paid before further treatment is performed (this is also applicable to no-showing). This fee is not covered by any insurance. By signing below you are agreeing to abide by this cancellation policy and to take personal financial responsibility for the cancellation fee should you violate this agreement.

FINANCIAL AGREEMENT

I understand and agree that, regardless of my insurance status, I am responsible for my account, have read and completed all the information on this sheet and certified it to be true to the best of my knowledge, and I will notify the office of any changes. In the event my account is forwarded to collections due to lack of payment, I will be responsible for any collection and attorney fees.

PAYMENTS

I agree and understand that I am personally liable to the medical service provider for payment of any balance on my account or on any account for which I am responsible for myself or as a parent or guardian (which may include professional service fees, **missed appointment fee of $40.00**, bounced check charges, etc.) regardless of whether insurance benefits have been applied for or received, including interest on any outstanding balance(s) at the rate of 18% per annum accruing 30 days after services are rendered and for any and all collection costs or fees, including but not limited to, 50% attorney's fees and court costs if the account(s) is/are turned over to a third party and/or attorney for collection. I agree and understand that if I do not dispute in writing the amounts and charges set forth in any statement within 30 days after its issuance date that I am agreeing that the amounts and charges set forth in any statements are fair, reasonable and accurate. I agree and understand that if I file an action/counterclaim against the medical service provider/practice and the medical service provider/practice incurs any costs and attorney's fees for its/their defense, I am liable for such costs and attorney's fees if the medical service provider/practice is the prevailing party in said proceeding, which shall include, but not be limited to, bankruptcy, arbitration, mediation, litigation or other processes.

Signature _____ Date _____

Print Name _____ Relationship to Patient _____