

WELCOME TO FOOTHILL OPTOMETRIC GROUP!

Personal Information

Last Name _____ Today's Date _____
First Name _____ Initial _____ Date of Birth _____ Age _____
Name you prefer to be called _____ Social Security _____
Title: Mr. Mrs. Ms. Dr. None Suffix _____ Gender: Male Female
Is Patient a child under the age of 18? No Yes Marital Status _____
Address #1 _____ Name of Spouse (If applicable) _____
Address #2 _____ Name of Children (If applicable) _____
City _____
State _____ Zip _____ Insurance Provider _____
Home Phone _____ Employment Status _____
Daytime Phone _____ Employer _____
Cell Phone _____ Occupation _____
Fax Number _____ How did you hear about our office? _____
Email _____

Insurance Information

Name of Insurance Company for vision care _____
Policyholder Name _____ Policyholder's Date of Birth _____
Social Security # _____ Name of Employer _____
Work Phone _____ Employer Address _____
City _____ State _____ Zip _____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS: By signing this form below, I authorize the release of any medical information necessary to process this claim and request payment of medical benefits to be made directly to Foothill Optometric Group, unless payment is made in full at the time of service. I also understand that it may be necessary for me to bill my own insurance company directly, or that a \$20.00 filing fee may be charged by Foothill Optometric Group to bill my insurance company if this office is a non-contracted provider.

Financial Responsibility

Your signature on this form acknowledges that you, the patient, agree to bear full responsibility for all services provided if:

1. It is determined that you are not eligible for insurance coverage.
2. The services are not covered under your benefit plan or we were not made aware of your coverage at the time of services. (Some non-contracted insurance companies have disclaimers stating that they will not guarantee coverage as quoted over the phone at the time of our coverage inquiry.)
3. The services have not been referred and/or authorized as required by your health plan.
4. You are seeking services "out of network" with a non-contracted provider.
5. A finance charge of 1.5% monthly applies to outstanding balance.

We reserve the right to charge a \$25.00 fee for all missed appointments that have not been cancelled 24 hours prior to the scheduled appointment time. This is because a block of time in the doctor's schedule has been allotted to you and may remain unusable by another patient.

If an order for contact lenses or glasses is placed by phone, a credit card number is required at the time the order is placed to pay for desired materials.

All charges are due and payable at the time of service unless otherwise specified by an insurance company contracted with us.

I have read and understand the above stated office policies. By signing this form, I agree to comply with these policies.

Signature

Date