FAMILY OPTOMETRIC CARE

J. Brent Meek, O.D. ▪ Lisa A. Kopper, O.D.

How were you made aware of our office? _____ Today's Date_____

Patient's Full Name _____Nickname_____

Gender: Male / Female Marital Status: Single____ Married____ Divorced____ Other____

Mailing Address _____City _____

State _____ Zip _____ Home Phone _____ Alt Phone _____

Occupation _____ Employer _____

Date of Birth _____ Age _____ SSN _____

E-Mail Address_____

I would like my yearly appointment recall reminders by: _____Mail _____Email

I would like my courtesy appointment reminders by: _____Phone _____Email

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Insurance for Eye Care _____ Insured Party's Name _____

Date of Birth _____ SSN or PIN _____ Employer_____

Relationship to Patient _____ Phone _____

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FEE POLICIES

The patient, not the insurance company, is responsible for his/her bill.

If current insurance information is provided, we will bill insurance for any covered services and materials. Copays, deductibles or charges not covered by your insurance are to be paid in full at the time of service. If you have any questions regarding fees or any of the information explained above, please discuss it with the receptionist **before** you see the doctor.

I have read and understand the fee policies and agree to pay for services rendered.

_____

Signature (Patient, Parent or Guardian)

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign this Acknowledgement****

The undersigned Patient or legally authorized representative of the Patient acknowledges that he or she personally received a copy of Family Optometric Care's Notice of Privacy Policies.

Signature:_____ Date:_____

Patient:_____

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For Office Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Policies. Acknowledgement could not be obtained because:

_____Individual refused to sign _____Communication barriers _____ Other (Specify:)_____