Patient Information

Name: _____Gender(must match insurance): Male/Female Birth Date: _____

Mailing Address: _____
Street/ PO Box City State Zip

Email Address: _____ Home #_____Cell#_____

Social Security #_____ Primary Care Doctor: _____ Previous Eye Doctor: _____

Employment Status: _____Employer: _____ Occupation: _____

Marital Status: Single/ Married/ Divorced/ Widowed Notification Preference: Call/ Text/ Email

Preferred Language: English/ Spanish / French

Race: American Indian/Alaskan, Asian, Black/African American, Hispanic/Latino, Pacific Island/Hawaiian, White

Ethnicity: Hispanic/Latino, Pacific Island/Hawaiian, Not Hispanic

Please initial to acknowledge your receipt of the following statements:

Financial Authorization:

_____I hereby give consent to Francis L Pinard OD PC or any doctors at this location, to provide eye care services to myself and/or person for whom I am legally responsible. I understand that I am ultimately responsible, regardless of my insurance status, for any charges incurred by me or any party for whom I am legally responsible.

Lifetime Insurance Signature:

_____I authorize use of this signature for all my insurance submissions. I authorize payment of benefits directly to Francis L Pinard OD PC. I authorize the release of any medical information necessary to process claims. I permit a copy of this authorization to be used in place of the original.

Medicare Waiver:

_____I understand that Medicare does not pay for service code 92015 (Refraction). I will be responsible for this $55.00 charge if not covered by a supplemental insurance policy.

Medicaid Waiver:

_____I understand that Medicaid does not cover any co-pays from other insurance companies. I will be responsible for the co-pay and will pay at the time of service.

Acknowledgement of Privacy Policy

_____I acknowledge that I have viewed and been offered a copy of the privacy policy (HIPPA) for Francis L Pinard, OD PC
(Policy is available at the front desk)

Acknowledgement of No Show Policy

_____We understand that situations arise in which you must cancel or change your appointment, it is therefore requested that you provide a minimum of 24 hours' notice. This will allow our staff optimal time to fill that opening with another patient who is on our waiting list. Any patient who No-Shows, or who fails to cancel their appointment within a 24 hour period, will be subject to a $50.00 rescheduling fee before another appointment will be scheduled. The rescheduling fees are the sole responsibility of the patient and must be paid in full **before** the patient's next appointment is scheduled.

Signature: _____ Date_____

Insurance Information

PLEASE HAVE INSURANCE CARDS READY FOR US TO MAKE A COPY

Responsible Party Information:

Person Responsible for this account: _____Birth Date: _____

SS # _____ Relationship to Pt: _____

Address (if different than patients) _____

Designation of Personal Representative

Patient Name: _____Date of Birth: _____

I, _____, give the following individual(s)
(Patient or Guardian)
access to my protected health information.

_____Emergency Contact: Yes/No Phone:_____
(Name)
Relationship to patient: _____

_____Emergency Contact: Yes/No Phone: _____
(Name)
Relationship to patient: _____

_____Emergency Contact: Yes/No Phone: _____
(Name)
Relationship to patient: _____

I understand that by granting the above-named individuals' access to my medical records, I allow my doctor and staff to speak with them regarding my diagnosis, treatment and overall care. They will have access to my exam notes as well as any supplementary testing, photographs, referral notes and financial information.

Signature: _____Date: _____
**** Designation of Personal Representative is valid until revoked by patient or guardian