Inverness Eye Care, P.C.

Patient History

Date: _____

Name_____ DOB _____

Address_____ City/Zip_____

Phone: Home_____ Cell_____ Day-Time_____

Pt. Employer_____ Occupation_____

Insurance Name_____ Contract Number_____

***Name of Policy Holder_____ *Birthdate_____**

Vision Insurance Name_____ Contract Number_____

Email address_____

PT. Marital Status (circle one) S M D W Spouse Name_____ Patient here: Yes No

Children names (responsible of): _____ Patient here: Yes No

Emergency contact:_____ Number: _____

I authorize the following person(s) to have access to my Inverness Eye Care, P.C. Medical Records:

1. (Name) _____ (Relationship) _____

2. (Name) _____ (Relationship) _____

"No-Show" Policy: Our physicians and staff work hard to meet the needs of our patients. We kindly ask that you give 24-hour notice if you need to cancel or re-schedule your appointment. As a courtesy we attempt to make confirmation calls in advance (during weekdays only) of your scheduled appointment, however you are responsible to keep track of your appointment. We will leave reminder messages at the phone numbers on file, unless otherwise instructed. A onetime consideration will be made for failure to show up for your appointment. Any subsequent "no-shows" will result in a $50.00 fee which must be paid prior to another appointment being scheduled.
Thank you for your understanding in this matter. _____ **Initial here**.

Financial Policy: We have contracts with many insurance companies to accept assignment of benefits for our services. Payment in full will be required unless insurance benefits to cover expenses can be verified prior to rendering services. You are responsible for knowing your insurance coverage and benefits. Your co-pay and deductibles will be collected at the time of your visit. We accept Cash, Visa, MasterCard, Discover and Checks. As a service to you we will file your insurance claim. You will be billed for any amount not covered by the insurance company, including deductibles and co-insurance. Payment is due upon receipt of your statement**.** _____ **Initial here**.

I request that payment of Medicare / Other Insurance Benefits be made to Inverness Eye Care, P.C. for services provided. I hereby consent to the treatment for myself or the above listed patient.

I authorize the release of any information needed for processing this or any related claim/s. I will permit a copy of the authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment.

I hereby accept financial responsibility for all charges and understand insurance will be billed as a courtesy. All unpaid balances will be charged a 1.5 percent rebilling fee assessed monthly. All returned items will be assessed a $30.00 fee in accordance with State of Alabama law 13.A-9-13.1. _____ **Initial Here**

Receipt of Notice of Private Practices: I have read a copy of the Inverness Eye Care, P.C. Notice of Privacy Practices available on our website or I was offered a copy in the office to read. I understand the Privacy Practices instituted by Inverness Eye Care, PC

I UNDERSTAND THIS IS A LIFETIME SIGNATURE AUTHORIZATION.

Patient Signature_____Date:_____