SPECIALTY
Eyecare Group
A MEMBER OF Vision Source™

# Patient Information Form

Patient's Legal Name: _______________________________________ DOB: ____________ Sex: M /F

Address: __________________________________________City: ________________State: _______ Zip: _________

Home Ph: ________________________ Cell Ph: ____________________ E-mail: ____________________________

Guardian #1 or Spouse's Name: ____________________________ Cell Ph: ____________________

Guardian #2: __________________________________________ Cell Ph: ____________________

Occupation/Grade: _________________________ Employer/School: _______________________________________

☐ I herby give permission for SEG & Affiliates to leave detailed messages on my voicemail/answering machine.

☐ I herby give permission for SEG & Affiliates to send me emails

In order to connect your account with a family member, please list their names and ages: (parents, children, siblings)

Name: ____________________________ Age: _______ Name: _______________________________ Age: _______

Name: ____________________________ Age: _______ Name: _______________________________ Age: _______

How did you find out about us? _____________________________________________________________________

Referred by: ______________________________________________________________________________________

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

- ☐ I was given to opportunity to read Specialty Eyecare Group's Notice of Privacy Practices. I have either read or I declined to read. I wish to continue my care with Specialty Eyecare Group under the terms of Specialty Eyecare Group's privacy policies.
- ☐ I am over 18 and allow my information be shared with my family for purposes of helping me decide upon my care and/or to ensure that billing is completed properly.

**Signature** ___________________________________________________**Date** ___________________________________

**FINANCIAL AGREEMENT**

**In signing this statement I agree to be financially responsible for all charges.** I understand that my insurance is not a substitute for payment and it is my responsibility to pay, in advance, the deductible, the co-pay and any other balance not paid by my insurance company. **I also understand that verification of my benefits is not a guarantee of payment.** Most insurance policies pay only a portion of the total fees. If you have questions about your coverage, please contact your insurance company. All accounts over 60 days will receive an interest charge of 18%.

I understand that I am responsible for charges for services and products that are not covered by my insurance plan.

**Signature** ___________________________________________________**Date** ___________________________________