Welcome to Gandy Eye Care

(Please fill in all blanks in order to be seen today)

Dr. Mr. Mrs. Miss. Rev. Other Name:_____(Nickname)_____
Mailing Address:_____City_____St_____ZIP_____

Please circle the one that applies: Single____ Married____ Widowed____Divorced____

Please circle your race(s): White____ Hispanic____African American____ Latino Other_____

Birthdate:____/____/_____Age:____M/F:____SS#_____DL#_____St:_____Exp:_____
Home:_____Cell:_____Email:_____
Would you like to "opt in" for text messaging regarding appointments and eyewear? YES or NO
Would you like to receive a summary of your exam sent to your email by patient portal? **YES or NO**

Employer/School:_____Occupation:_____
Parent/Spouse:_____Phone:_____
Emergency Contact:_____Phone:_____

IN ORDER TO BE SEEN TODAY, THE FOLLOWING SECTIONS MUST BE COMPLETED:

PERSON RESPONSIBLE FOR PAYMENT :_____
(Patient or Guarantor: NOT AN INSURANCE COMPANY)
Person's DOB:_____/_____/_____ SS#_____

I acknowledge that I am ultimately responsible for payment of all my services and products. I also realize it is my responsibility to make sure my insurance pays and to personally know all my benefits given to me by my insurance. I know that it is not the responsibility of anyone at Gandy Eye Care to understand my insurance. In the event that my insurance does not pay, then I know I will be required to pay the expenses.

ULTIMATELY YOU ARE RESPONSIBLE FOR PAYMENT OF ALL SERVICES AND PRODUCTS AT THE TIME OF SERVICES: All copayments and individual portions of your balance are due at time of service. If you are covered by an insurance plan we will bill your insurance directly for their portion, If for any reason your insurance does not remit payment you will be responsible for the remainder of the balance.

If you believe that your insurance company provides coverage for our services, but we are not on your provider list, payment in full for all services and materials is due at the time of service. Please submit the provided receipt with your claim form directly to your insurance company. This will expedite the reimbursement of funds directly to you.

I authorize the release of any medical or other information necessary to process any claims arising from the services and materials provided. Also, request payment of government or private insurance benefits to the physician accepting assignment for services and materials provided. I also understand that I assume all financial responsibility for this account for any amount due, regardless of insurance coverage. Should it be necessary to hire an attorney for the collection of any past due balances owed by me or a family member for whom I am responsible or have signed, then Gandy Eye Care shall be entitled to recover the attorney fees equal to 33 and 1/3 of the principal balance then outstanding, and any and all costs incurred in said collection, whether before or after lawsuit has been filed. I realize that I should not drive while my eyes are dilated, medicated, or patched. ACKNOWLEDGMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES. I acknowledge that I was provided a copy of the notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

_____

Patient Name (Please Print) **Birth Date**

_____

Patient Signature or Parent/Authorized Representative (if applicable) **Date**

If there is any other person who you would like to obtain medical information concerning you, please print their name and DOB below*

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