Patient Name: ________________________ DOB: __________ SS#: ______________

Mailing Address: __________________________________

City: _______________ State: ______ Zip: ________ Phone: ___________________

Email Address: ________________________________

Insurance Policy Holder Information:

Name: ________________________ DOB: ________ SS#: _________________

Policy Holder's Employer: __________________________________

Policy Holder's Relationship to Patient: _____________________

PATIENT MEDICAL INSURANCE INFORMATION

Please note that full payment for copays, overages, non-covered items, etc. is required at the time services are rendered. Verification of eligibility and authorization numbers from your insurance company is not a guarantee of payment. Final determination of payment is made when said insurance company receives the actual claim. Please remember that filing insurance is a courtesy and you are ultimately responsible for knowing what your insurance benefits are.

Assignment and release- (Permission to file your claim to your insurance company for you.) I hereby authorize the provider to release any information required to process my insurance claim. I also authorize my insurance benefits to be paid directly to the doctor. I understand that I am fully and financially responsible for any charges my insurance company cannot or will not pay.

_______________________________ ______________________________

Patient's Signature Date

ATTENTION CONTACT LENS PATIENTS

If you are having a contact lens evaluation today, please note the following: A contact lens evaluation is elective and is, therefore, **not covered by your insurance company**. If you are using your contact lens allowance to purchase your contact lenses today, you may deduct the cost of your evaluation from the allowance. If you do not purchase contact lenses today or if you are using your insurance to purchase your glasses, you are responsible for paying the contact lens evaluation fee.

I understand that Ardmore Premier Eyecare will bill me for any items and/or services denied by my insurance company. I understand that I am personally and financially responsible for these charges and will not hold Ardmore Premier Eyecare liable for my insurance policy.

______________________________________ _____________________________

Patient's Signature Date

A R D M O R E

PREMIER EYECARE

Acknowledgement of Receipt of the

Notice of Privacy Practices

I acknowledge that I have been offered a copy of the Ardmore Premier Eyecare Notice of Privacy Practices to read today and a copy to take home.

Patient Name (please print) __________________________________

Signature (patient/guardian) _____________________________Date___________

Names of People We May Release Medical Information To:

NAMES	**PHONE NUMBERS**
_______________________________	______________________________
_______________________________	______________________________
_______________________________	______________________________