Welcome to Our Office

The mission of Pemberton Eye Optometry is to contribute to a lifetime of healthy vision, providing each patient with the highest quality medical and vision care and consequent quality of life. Everything we do shall communicate this. The information and questions below will remain confidential, and are critical to the evaluation of your vision and health. Therefore it is very important that every question be answered in detail. Thank you.

Patient Information:

Name: ____
Dr. Mr. Mrs. Ms. Mstr. Miss (circle one) First Mi Last Suffix: Nickname:

Physical Address: ____
Street Apt # City State Zip

Mailing Address: ____
Street Apt # City State Zip

Date of Birth: ____________ SSN: ____________ Sex: Male / Female Marital Status: Single/ Married/ Divorced

Preferred Language: English / Other ____________ Race: (circle one) African American, Arab, Asian, Caucasian, Hawaiian, Hispanic/Latino, Indian, Multiracial, Unknown, Declined. Ethnicity: (circle one) Hispanic/Latino, Other, Declined

Contact Information: ____
Home Mobile Work Email

Employment/School: ____
Employer or School Occupation or Grade

____
Address City State Zip

Referral Information: How did you hear about our office? (circle all that apply) ad, social media, yellow pages, insurance, friend

if friend please let us know so we may thank them ______________________________

other ____

Family Members: Please list any family members who are or may be in the future a patient in our office.

____
Name: DOB SSN Relationship (spouse, child, parent, step child etc)

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Primary Care Doctor & Pharmacy:

Doctor: ____
Name Office/Group Name

____
Address Phone Fax

Pharmacy: ____

____
Address Phone Fax

Emergency Contacts: Who should we contact in case of emergency?

____
Name: DOB Relationship (spouse, child, parent, step child etc)

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Insurance Information: Please present your insurance cards to the front desk for scanning. We can not file insurance for you without having a current card on record.

Primary Medical: ______________________________
Company Name | Policy Number | Address

Secondary Medical: ______________________________
Company Name | Policy Number | Address

Vision Plan : ______________________________
Company Name | Policy Number | Address

Policy Holder: ______________________________
Name: | birthdate | ssn | relationship (self, spouse etc)

____
Address: Street | Apt # | City | State | Zip | Phone number:

____
Occupation: | Employer: | Address:

Responsible Party: Please list who in the household is responsible for payment and receiving billing notices.

____
Name: | DOB | SSN | Relationship (spouse, child, parent, guardian)

____
Address: Street | Apt # | City | State | Zip | Phone number:

____
Occupation: | Employer: | Address:

Financial Assignment and Agreement

1. Please remember that insurance is considered a method of reimbursing the patient to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

2. Payment is expected to be paid at the conclusion of each visit unless our office participates in your insurance or other arrangements have been made prior to your visit.

3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to be released to the health care financing administration, it's agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.

4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hear by authorize said assignee to release all information necessary to secure the payment.

5. If Pemberton Eye has not heard from my insurance within 60 days of submission, I will be responsible for any balance due.

6. If, during an examination, a medical diagnosis is found, your exam may no longer be considered routine and may be sent to your primary medical insurance rather than an associated vision plan. All applicable specialist co-pays, deductibles, and coinsurance may apply.

7. A 1.75% interest will be charged per month on any accounts 30 days past due. If my account becomes assigned to a collection agency, I agree to pay all costs of collection, all agency fees, all court costs, and all attorneys fees as allowed by law.

8. I understand that this serves as my signature on file for all insurance and records release purposes.

9. I understand that there is a return check fee of $50. Return check fees are assessed on any bad/returned check including ACH payment plans. $50 will be assed on each occurrence. Return check fees may be withdrawn automatically from your financial institution as soon as funds are available.

10. Any accounts on a payment plan will be assessed a $29 late for any accounts that are not processable and become past due for each month and may be electronically withdrawn when funds are available.

____
Signature | Date | Full Name