FISHEL

Patient Name:		
Address:		
City:	State:	Zip Code:
Home Phone #:	Work Phone #:	Cell Phone #:
Email Address:		
Referred to our practice by:		
Gender: ☐ Male ☐ Female	Date of Birth:	
Social Security #:	Marital Status: ☐ Single ☐ Widowed ☐ Married ☐ Divorced	
Employment Status: ☐ Employed Full-Time ☐ Employed Part-time ☐ Full-time Student ☐ Not a Student ☐ Not Employed ☐ Part-time Student ☐ Retired ☐ Self-Employed		
Employer:	Occupation:	
Preferred Language: ☐ English ☐ Spanish	Race: ☐American Indian/Alaska Native ☐Asian ☐African American ☐Caucasian ☐Hispanic ☐Native Hawaiian/Other Pacific Island	
Ethnicity: ☐Hispanic or Latino ☐Native Hawaiian/Other Pacific Island ☐Not Hispanic or Latino		
Communication Preference: **PLEASE CHOOSE ONE** *Email US Mail Telephone Text*		
Guarantor Information		
Responsible person for payment:	Relationship to patient:	
Address:	City, State, Zip Code	
Phone # of Responsible Party:	Social Security #:	Guarantor DOB:
Insurance Information		
Primary Insurance	Cardholder's Name & Date of Birth	Relationship to Patient
Secondary Insurance	Cardholder's Name & Date of Birth	Relationship to Patient

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Updated 04/21/2017 found under I-Drive -Forms –Patient Demographics

We provide our patients the option to participate in our online patient communication system. Some of the features include the ability to: Request appointments online, Confirm appointments via Email, Receive Text Message Appointment Reminders, Submit Patient Satisfaction Surveys and Refer your Friends Online. You may opt-out of communications at any time by clicking on the unsubscribe link in the footer of each email or by replying to a text message with "STOP". Standard Text Messaging rates apply. Your information is secure.

Payment Policy

Doctors' Fees, Co-pays, Deductibles and Co-Insurance: Co-pays are collected at the time of check-in. Insurance deductibles and fees for services not covered by your insurance policy, if known are due at the time service is rendered. We accept cash, check, Care Credit and most major credit cards.

Contact Lens Fitting Fees: All fitting fees are due on the day you are fit with contact lenses and are separate from a routine eye exam. A fitting may range from $85- $250 depending on the contact lens to best fit your visual needs. Hard contact lenses have a 90-day warranty from the date they are ordered. Fittings are a total of 3 visits or less within the 60 day time frame and soft fits include one trial pair of contact lenses. If you are not able to show up for an appointment and the office is not given advance notice, then this visit will be part of your 3 visit fitting. Contact lens fittings are subject to an additional fee after 60 days from the original fitting date. Fittings are a service and non refundable.

Fee for Contacts and Glasses: We require half down when ordering contact lenses and eyeglasses. Full payment is required on the day they are dispensed. ***If contact lenses' or eyeglasses' orders are cancelled, returned, or not picked up within 60 days, you will be charged a 20% restocking fee or forfeit your deposit. This amount will not be modified or waived for any circumstance. Full payment will be required to reorder.***

No Show Fee: You will be a charged a $35 No Show Fee for all missed and no show appointments. We request 24 hours advanced notice for any cancellations or rescheduling of appointments.

About Insurance: Please present your insurance information at time of service. If insurance information is not provided, full payment is expected when services are rendered. We will provide you with receipts so that you may file your own insurance claim. We accept assignment on the following insurances: Medicaid, VSP and Medicare. We will calculate co-pay and deductible amounts for you. We will work hard to ensure that you obtain your proper benefits; however, you are ultimately responsible for all deductibles, co-payments, non-covered charges and claims denied by your insurance carrier. If a medical diagnosis is determined during your visit, your medical insurance will be filed.

If you have questions regarding this policy, please do not hesitate to ask.

I agree to the above policies regarding payment. Should my account become delinquent and require collection services, I agree to pay all reasonable collection and administrative fees.

Signature:	Date: