

PERSONAL- Read carefully before signing and fill out ALL information including initials

FULL NAME _____ NICKNAME _____ DOB ___/___/___

STREET ADDRESS _____ CITY _____ STATE ___ ZIP _____

HOME PHONE _____ CELLPHONE _____ EMAIL _____

I, the undersigned, give 20/20, it's employees and agents, express permission to contact me at any phone number(s), for the purpose of treatment, appointments, insurance and payment.. _____ Initials

SSN _____ EMPLOYER _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ WORK PHONE _____

PREFERRED PHARMACY AND PHONE# _____

AGE _____ SEX _____ MARITAL STATUS (CHECK ONE) ___S___M___W___D _____ I have executed Advanced Directives that express how my medical care is to be carried out in the event I become unable to communicate those instructions.

CONTACT/REFERENCES

NAME OF SPOUSE/ PARENT/FRIEND _____ RELATION _____

HOME PHONE _____ WORK PHONE _____ STREET ADDRESS _____

DOB ___/___/___ CITY _____ STATE _____ ZIP _____

EMPLOYER(if parent or spouse) _____ STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT(not living in your home) _____ Phone _____

RELATION TO PATIENT _____ HOME PHONE _____

INSURANCE

NAME OF PRIMARY INSURANCE CARRIER _____

IDENTIFICATION # _____ GROUP # _____

NAME OF SUBSCRIBER _____ DATE OF BIRTH _____ RELATION TO PATIENT _____

NAME OF SECONDARY INSURANCE CARRIER _____

IDENTIFICATION# _____ GROUP# _____

NAME OF SUBSCRIBER _____ DATE OF BIRTH _____ RELATION TO PATIENT _____

***Note: We are obligated to collect all co-payments and deductibles from insured at the time of service.**

All fees are due at the time of service. We accept cash, debit cards, and most major credit cards. The patient is responsible for any collection fees and/or attorney fees if this account is not paid within 60 days. The patient is responsible for all non-covered tests and eye refractions not covered by their insurance. I, the undersigned, accept the fees charged as a legal and lawful debt. Should it become necessary to forward my account for collection, I agree to pay all monies due, including a **33 1/3%** collection fee, Attorney Fees, and/or Court costs, if such be necessary. I waive now and forever, my right of exemption under the laws of the Constitution of the State of Alabama and any other state.

YOUR SIGNATURE IS YOUR AGREEMENT TO PAY FOR ALL NON-COVERED SERVICES PROVIDED BY 20/20 OPHTHALMIC ASSOCIATES P.C.

TODAY I WILL BE PAYING BY _____ CHECK _____ CASH _____ CREDIT CARD

I request payment of government benefits or insurance assignment to 2020 Ophthalmic Associates P.C.

PATIENT SIGNATURE _____ DATE _____