Patient Information

Patient Code: _____

PLEASE PRINT LEGIBLY

Circle One ○ Male ○ Female

Rabbi / Dr. / Master / Mr. / Mrs. / Ms / _____

Date of Birth

First Name _____ MI _____ Last

Address

_____

Soc. Sec. # _____ E-mail address: _____

Phones: Home # _____ Cell #

_____ Work # _____ Ext _____

***Would You Like To Be Texted For Appointments? ○ Yes or ○ No (Circle One) ***

Employer: _____ Married? ○ No ○ Yes →

Spouse's Name _____

***FOR CHILDREN or DEPENDENTS, please give parents' (or legal guardians') information ***

Mother's Name: _____

Address (*if different*): _____

_____

Social Security #: _____

Home Phone #: _____

Cell / Work # (*CIRCLE ONE*) _____

Father's Name: _____

Address (*if different*): _____

_____

Social Security #: _____

Home Phone #: _____

Cell / Work # (*CIRCLE ONE*) _____

Health Ins (Ex:BcBs): Co: _____ ID# _____ Group# _____

Insured Worker's Name _____ Worker's DOB _____ SSN _____

Relationship to Patient _____ Employer giving the Insurance _____

Insured's Address (*if different*) _____

2. Vision INS or Secondary Co: _____ ID #

_____ Group # _____

Insured Worker's Name _____ Worker's DOB: _____ SSN: _____

Relationship to Patient _____ Employer giving the Insurance _____

1. Whom may we thank for referring you to our office?

Name of friend / relative / Dr.? _____ Phone # _____

2. If none of above how did you choose our office? ○ Website: DrShermanEyes.com

○ Facebook ○ Recall Card/ Call ○ Google Reviews (**Won't you please leave A+ review, too?**)

○ Saw Sign/Building ○ Insurance List/Website ○ Other _____

FINANCIAL POLICY: Our office policy calls for payment at the time of service. *Patients are required to make a 50% down payment on all materials ordered.* Payment in full is required when materials are dispensed.

I understand that it is my responsibility to know my insurance benefits and requirements. **If referrals are required, it is my responsibility to obtain ALL necessary referrals before my appointment.** If I do not have my referral at the time of my appointment, I will pay Dr. Sherman **in full** at the time of my visit.

If your insurance does not pay the anticipated amount or if your insurance pays you directly, you are responsible for any balance. I have read and agree to all the provisions of the office financial policy. I hereby authorize Dr. Sherman to treat the patient named above.

Signed (X) _____ **Date**: → _____

Patient (**if 18 or older**), ELSE Parent/Legal Guardian, or Authorized Representative's Signature

IF YOU ARE NOT THE PATIENT, print your name: → _____ Relationship to patient: _____

Please SIGN ON THE OTHER SIDE OF THIS FORM

1.Insurance Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize Dr. Howard Sherman to act as my agent in obtaining payment of my health or other insurance and/or Medicare benefits. I understand my signature requests that payment be made and authorizes release of medical and other information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS 1500 form or elsewhere on other approved claim forms or electronically submitted claim forms, my signature authorizes releasing the information to the insurer or agency shown. My signature also authorizes the payment of these benefits directly to Dr. Howard A. Sherman on my behalf for any services and materials furnished.

Signed (X) _____ Date: → _____

Patient or Authorized Representative's Signature

If not the patient: print your name: _____ Relationship to patient: _____

2. Notice Of Privacy Practices

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly,
- Obtain payment from third-party payers,
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices. I understand that I may revoke this consent in writing at any time and that it will not affect any prior action taken based on this consent.

Signed (X) _____ Date: → _____

Patient or Authorized Representative's Signature

If not the patient: print your name: _____ Relationship to patient: _____

3.Cancellation & Delinquent Fee Policy

You are responsible for paying your account in full within 30 days, even if you have not returned to pick up your eyewear. After 30 days, balances are considered delinquent and are subject to a billing service charge of $5.00 per month. If a collection agency is needed, you will be responsible for *all* charges incurred from the collection agency. ***AT LEAST 24 HOURS ADVANCE NOTICE*** **is required to change or cancel an appointment WITH NO PENALTY**. Missed appointments or appointments cancelled ***without 24 hours advance notice are subject to a cancellation fee of $50.00***.

Signed (X) _____ Date: → _____

Patient or Authorized Representative's Signature

4.Contact Lens Wearers:

If you are a contact lens wearer, your needs for visual care are more complex that those of the patients who chooses to wear glasses only. If you are a contact lens wearer, you will be receiving additional testing and evaluation during your visit with us. We charge one fee for contact lens fitting and that includes all follow up visits until final cl RX is done, it also includes a free 6 month cl follow up visit. Please Initial _____

MEDICARE Patients **ONLY**

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Howard Sherman for services furnished me by his office. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Dr. Howard Sherman accepts the charge determination of the Medicare carrier as the full charge, and I'm responsible only for the deductible, co-insurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare Carrier.

Signed (X) _____ Date: → _____

Patient or Authorized Representative's Signature

If not the patient: print your name: _____ Relationship to patient: _____