PATIENT INFORMATION FORM

Date:

Patient Name:

Age: Sex: M F Marital Status: S M D W

Date of Birth: Ethnicity:

Social Security Number:

Driver's License Number:

Mailing Address:

City:

State: Zip:

Home Phone:

Cell Phone:

Email Address:

Employer: Employer Phone:

Preferred Pharmacy:

Parent/Spouse Name:

Social Security Number:

Cell Phone:

Employer:

Work Phone:

Primary Medical Insurance:	**Secondary Medical Insurance:**
Policy Number:	Policy Number:
Group Number:	Group Number:
Insured's Name:	Insured's Name:
Insured's Date of Birth:	Insured's Date of Birth:
Vision Insurance:	**Secondary Vision Insurance:**
Policy Number:	Policy Number:
Group Number:	Group Number:
Insured's Name:	Insured's Name:
Insured's Date of Birth:	Insured's Date of Birth:

RESPONSIBLE PARTY IF DIFFERENT THAN PATIENT:

Relationship to patient:

Driver's License Number:

Social Security Number:

Date of Birth:

Employer: Employer Phone:

Home Phone:

Cell Phone:

Mailing Address:

City:

State: Zip:

PLEASE TURN OVER AND COMPLETE OTHER SIDE

FAMILY MEMBERS SEEN IN OUR OFFICE **RELATIONSHIP**

_____ _____

_____ _____

_____ _____

IMPORTANT INFORMATION: Payment is due from the patient at the time services are rendered. Patients are responsible for any applicable co-pays or deductibles.

REFRACTIONS are a necessary part of our complete eye examinations and are used to determine your glasses and contact lens prescription. Refractions are not covered by most insurance programs. Refractions are $30.00 and must be paid at the time of service if not covered by your insurance. **Patients are always responsible for services that are not covered by their insurance.**

VISION INSURANCE PLANS VS MEDICAL INSURANCE PLAN COVERAGE: You may have **vision** insurance coverage in addition to your **medical** insurance coverage. **Vision** insurance includes coverage for periodic routine eye exams and partial coverage on glasses or contacts. This coverage includes things of a routine nature such as being nearsighted or farsighted. We are a provider for many vision plans but not all of them. Please let the receptionist know what your particular plan is. If we are not a provider we can offer you our **"in house"** discount. **Medical** insurance coverage refers to handling more complex cases associated with eye problems that require a more detailed examination, discussion and medical treatment. Your **routine vision** insurance does not cover these items but your **medical** insurance often allows some coverage depending on deductibles, co-pays and if we are a provider of your insurance plan. If your medical coverage does not cover these services you will be responsible for the unpaid balance. **You are responsible for any unpaid balance.**

TELEPHONE CONSUMER PROTECTION ACT: By signing below you agree, in order for us to service your account or to collect monies you may owe, Dr. Paris Mullins, Jr. and/or our agents may contact you by telephone at any phone number associated with your account including wireless telephone numbers, which could result in charges to you. We may also contact you by sending you text messages or emails using the email address you provide to us. Methods of contact may include pre-recorded/artificial voice messages and/or use of an automatic dialing device as applicable.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: Dr. Paris Mullins, Jr. is authorized to furnish any medical information requested by insurance companies with whom I have coverage with or any public agency which may be assisting in payment of my care. I also authorize the disclosure of my information to the following people:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

ASSIGNMENT AUTHORIZATION: If assignment applies to any charges incurred, I hereby authorize the insurance company to make payment to Dr. Paris Mullins, Jr.

STATEMENT OF RESPONSIBLILITY: The above information is given for the purpose of obtaining treatment from Dr. Paris Mullins, Jr. I understand that payment is expected at the time of each visit and that I am responsible for all charges incurred on this account. In the event that charges become delinquent I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees (33.33%), attorney fees, and/or court costs if such be necessary. I waive now and forever my rights of exemption under the laws of the state of Alabama and any other state.

OPTICAL MATERIALS: I certify that I understand that cancellation of optical material orders are not permitted after they have been ordered or after payment has been received toward a future order. I understand that all personal payments or insurance payments that have been made toward optical materials will be forfeited if the complete balance has not been paid within 90 days from the order date.

SIGNATURE:_____ **DATE:**_____