Patient Information

Name: _____ **Sex: F M**

Address: _____ **Marital Status: S W D M**

City: _____ **State:** _____ **Zip:** _____ **Date of Birth:** _____

SS#: _____ **Co-Pay** _____ **Age:** _____ **Race:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Cell Carrier: _____ **E-mail:** _____

Person to notify in case of emergency:

Name: _____ **Phone #:** _____ **Relation:** _____

Responsible party

Name: _____ **SS#:** _____

Address _____ **City/State/Zip** _____ **Phone #** _____

Referring source: _____

1. **List any family members that are patients here:** _____
2. **Nature of problem(s):** _____
3. **Employed by:** _____

AUTHORIZATION TO RELEASE INFORMATION: I authorize INSTITUTE FOR TOTAL EYE CARE, P.C., to release any medical information necessary to process health insurance claims. I also authorize payment directly to the physician of the surgical and/or medical benefits, if any, otherwise payable to me for this service as described. ACKNOWLEDGEMENT OF RESPONSIBILITY: I understand that I am financially responsible to you for all professional services rendered, including but not limited to those services which are not covered by Blue Shield PMD/Medicare programs or other private and commercial insurance programs (co-payments, refractions, and/or deductibles). I also understand that if I have an HMO insurance and do not obtain the proper referral number prior to my visit, that I am financially responsible for any charges incurred. I understand that payments for these charges are due at the time of service. AGGREEMENT TO PAY: 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. Also, I acknowledge receipt of ITEC's "Notice of Privacy Practices" and further authorize ITEC, its employees and or agents, to contact me at any/all phone numbers, including my cell phone I have provided and to discuss with any family members or care givers anything about my private health information insurance and payments.

You agree, in order for us to service your account or to collect monies you may owe our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

PATIENT/PARENT/GUARDIAN-SIGNED _____ **Date:** _____