Concord Eye Care Center OD PA
Sonnie Bryant, O.D.

Patient and Responsible Party Information

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ Social Security Number: _____ Sex: _____

Address: _____ City: _____

State, Zip: _____ Email: _____

Telephone Number: Are text messages okay? (Please Circle) Yes No

Home: _____ Cell: _____ Work: _____

Employer: _____ Occupation: _____

Payment Information:

We accept cash, check, Care Credit, and all major credit cards.

Payment Policy: Payment in full is expected at the time professional services are rendered and/or materials are ordered. We are happy to file for insurance payment when applicable. ***Initial***_____

Failure to pay balances in the allotted time will result in patients incurring additional costs of collection including, but not limited to attorney or legal fees, collection agency fees and finances charges. ***Initial***_____

Acknowledgment:

If insurance is filed on my behalf, I authorize my insurance benefits to be paid directly to Concord Eye Care Center. ***Initial***_____

I agree that unless Concord Eye Care Center and my insurer have a prior agreement, I am personally responsible for all non-covered services, co-pays and deductibles.
Initial_____

I authorize the release of medical information to insurance carriers or other physicians if it is deemed necessary by my optometrist for financial or consultative purposes.
Initial_____

Responsible Party (Please Print) _____

Responsible Party (Signature)_____ Date_____

AUTHORIZATION FOR RELEASE OF INFORMATION:

Concord Eye Care Center is authorized to release protected health information, pertaining to the above named patient, in the methods below: (Initial)

_____ Leave information on voice mail
_____ Give materials (contacts, glasses, prescriptions) to authorized person.
_____ Other: _____

AUTHORIZED RECIPIENTS:

_____ Relationship: _____
_____ Relationship: _____

DESCRIPTION OF INFORMATION TO BE RELEASED *(initial)*

_____ All Information
_____ Financial or billing information
_____ Medical information including results from any test
_____ Other: _____

RIGHTS OF THE PATIENT: I understand I have the right to revoke this authorization at any time by sending a written notification. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by state or federal law. I understand I have the right to inspect or copy the protected health information to be used or disclosed as described in this document, and that I may do this by written notification. I understand my treatment will not be conditioned on signing this authorization.

Print or Type Name of Patient or Personal Representative:

_____

Signature of Patient or Personal Representative:

_____ Date: _____