McGEE, PICKARD, & ROBINSON EYE ASSOCIATES

# Welcome To Our Office

Thank you for selecting our eye care team! We value the trust you have placed in us and we will do everything possible to earn that confidence. It is our mission to provide you with the best possible eye care and eyewear available today. The information located in the left column below is the data our office currently has on file for you. To help us meet all your needs and to comply with government regulations, we ask that you review the information for accuracy and document any corrections in the right column. If you have any questions or need assistance, we will be happy to help you.

## Patient Information

Name: Middle Initial: Sex: ______________________
Date of Birth: Marital Status: ______________________
Social Security Number: ______________________
Address: ______________________

______________________

______________________
Home Phone: (405) ______________________
Work Phone: (405) ______________________
Email: ______________________
Employer: ______________________

## Person Financially Responsible For This Patient's Account

Name: ______________________
Date of Birth: ______________________
Social Security Number: ______________________
Address: ______________________
, ______________________
______________________
Cell Phone: ______________________
Home Phone: ______________________
Employer: ______________________

## Insurance Information

**Primary Insurance**
Name of Insurance: ______________________
Patient relationship to the insured party: ______________________
Policy Number: ______________________
Group Name: Group Number: ______________________
______________________

**Secondary Insurance** ______________________
Name of Insurance: ______________________
Patient relationship to the insured party: ______________________
Policy Number: ______________________
Group Name: Group Number: ______________________

## Authorization and Acceptance

I authorize the release of any information, including records of any treatment or examination rendered to me or my child during the period of care, to third party payers and/or clinic insurance benefits otherwise payable to me. I understand that my insurance may pay less than the total amount due for services or goods delivered. I also understand that I am responsible for any portion of my account not paid by insurance within 60 days. I have no insurance or if my insurance plan has no formal agreement with the clinic, I understand that I am responsible for my entire account balance when services and/or materials are delivered to me. I understand and agree that there will be a Late Charge of $5 per month of any past due acct over 60 days. I also agree that if I am in default of this agreement, I will pay all reasonable & legal fees, court costs, & other costs necessary to collect the debt, including fees charged by a collection agency.

***I have read or declined to read the Notice of Privacy Practice offered to me by McGee, Pickard and Robinson Eye Associates***

Signature: ______________________________________ Date: ______________________

☐ **May release medical records/appointments times to: ______________________(other than myself)**