1305 N 16th Ave.
Durant, OK 74701
580-920-0400
pfecdurant@gmail.com

Premier
Family Eye Care

PATIENT INFORMATION

Name:	
Date of Birth:	
Social Security #:	
Mailing Address:	
City, State, Zip:	
Phone:	
Email:	

PFEC needs consent to begin communicating with you by text or email. This form collects your name, date of birth, email, and other personal information for the purposes of updating your patient record with your consent to communicate with you by text and/or email.

Text Permission:	☐ YES	☐ NO
Email Permission:	☐ YES	☐ NO

EMERGENCY CONTACT INFORMATION:

Name:	
Relationship:	
Phone:	

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INSURANCE INFORMATION

Is the policyholder different from the patient?	☐ YES *(If yes, please continue to fill the fields below)* ☐ NO *(If no, please skip this section)*

Policyholder's Name:	
Date of Birth:	
Social Security #:	
Mailing Address:	
City, State, Zip:	
Phone:	
Email:	

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Please choose one of the statements below:

❏ I **DO NOT** Authorize Premier Family Eye Care To Release Any Medical Or Vision Information.

❏ I Authorize Premier Family Eye Care To Release Any Future Medical And Or Vision Information To The Following Individual.

NAME: _____

RELATION: _____

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____

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PFEC POLICIES

PLEASE READ THE BELOW STATEMENTS IN ENTIRETY PRIOR TO SIGNING.

FINANCIAL POLICIES

- Compensation for services rendered (fees and/or co-pays) are due in full at the time of service.
- PFEC accepts cash and checks (with valid driver's license), and all major credit cards.
- If you have any questions regarding our payment policy, or in cases of financial hardship, please discuss financial arrangements with our staff prior to the services being rendered. We will help develop a payment plan that you can meet if needed.
- There is a $35.00 returned check fee due and payable from you for each check payment returned to us by your bank. Other applicable fees may apply.
- Accounts that are more than 120 days overdue are considered delinquent and will be turned over for collection or legal action and/or a $50 fee, including interest accrual, may be applied to your outstanding balance.

PLEASE BE AWARE THAT ALL SALES ARE FINAL AT THE TIME OF PURCHASE AND WE HAVE THE RIGHT TO REFUSE SERVICE TO ANYONE.

APPOINTMENT POLICIES

- In order to minimize waiting time, patients are expected to arrive 15 minutes before their scheduled appointment time in order to fill out any necessary paperwork.
- In fairness to other patients and our staff, we require at least 24-hours notice when canceling or rescheduling appointments.
- Patients with 2 missed, canceled and/or rescheduled appointments with less than 24-hours notice result in becoming a walk-in only status. The patient will be welcome to come on any given day and wait to be seen, but PFEC will not guarantee the patient will be seen.
- PFEC reserves the right to dismiss patients at any time.

INSURANCE POLICIES

- As a service to our patients, we will bill your insurance carrier(s), provided proper documentation is provided to us.
- Every effort will be made to estimate your co-payments, deductibles and coinsurance, which are due at the time of service, but the ultimate responsibility for any unpaid balances rests on the patient.

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- Some benefit plans require pre-authorization and specialist referral forms from your primary care physician. Please provide the proper insurance plan identification and forms necessary prior to your visit.
- All co-payments or patient out-of-pocket fees are due and payable at the time of service.
- Visits following the initial consultation will require payment for deductible, co-payment, co-insurance, and/or non-covered services. Periodic postoperative office visits may or may not be covered under your insurance plan; however, these may be required by the attending doctor to monitor your health.
- Many insurance companies take excessive time to pay; appropriately filed claims are frequently lost or delayed. Every effort will be made to arrange payment in a reasonable manner.
- You will receive a monthly statement showing your account balance if a service is not paid for by either yourself or your insurance company.

WORKERS COMPENSATION POLICIES

- If your injury is work-related, we require the necessary insurance billing information, case worker or adjuster contact information, and employer authorization form prior to your office visit or treatment.

ASSIGNMENT OF INSURANCE BENEFITS

- I hereby assign all medical, surgical and/or vision benefits, including major medical benefits to which I am entitled, private insurance, and any other health plans, to Premier Family Eye Care. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. I hereby authorize said assignee to release all information necessary to secure payment.

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____

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HIPAA INFORMATION & CONSENT

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

A Notice of Privacy Practices should be available to you in the office. The notice provides information about how we may use and disclose protected health information about you in order to carry out treatment, payment, and healthcare operations, and for other purposes permitted or required by law. The notice also contains information about your rights under the law.

Additional information is available from the U.S. Department of Health and Human Services.

By signing below you understand and agree to the terms of our notice of privacy practices which include:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Authorization is required for certain disclosures of your Protected Health Information.
- You have the right to opt out of fundraising communications.
- You have the right to restrict disclosures of your Protected Health Information under certain circumstances.
- You have the right to be notified of a breach of unsecured Protected Health Information.

By signing below you understand and agree that:

- The practice has a Notice of Privacy Practices that you have had the opportunity to review.
- The practice reserves the right to change the Notice of Privacy Practices and if we change our notice you may obtain a revised copy by contacting our office.
- You may revoke this consent in writing at any time and all future disclosures will cease.
- The practice may condition treatment upon the execution of this consent.

SIGNATURE: _____

DATE: _____