PATIENT INFORMATION

Date: _____

Name: Last: _____ First: _____ Initial: ____
Date of Birth: ____/____/____ Age: _____ Social Security:_____
Address: _____ Apt. #:_____
City: _____ State: _____ Zip: _____

Please Circle: Single / Married / Divorced / Domestic Partner / Widow

Daytime #:_____Work #: _____ Ext: _____
Cell #: _____ E-Mail: _____

Occupation: _____Employer:_____

Name of Spouse/Partner: _____
Date of Birth: ____/____/____ Employer: _____

In the Event of an Emergency, do who we notify? _____
Telephone: _____ Relationship: _____

To whom, if anyone, excluding any insurance company/companies which you have authorized us to submit partial or total payment on your behalf, **do you authorize the release of personal information, which may include but not limited to, medical information, i.e., diagnosis, prognosis, medicines taken/prescribed, prescription information such as Spectacle Rx, Contact Lens Rx, dates of visits, charges, balances and/or any or all demographical information?**

Such person(s) may include: Spouse, caretaker, child, children, Doctors office, retail establishment(s), e.g. LensCrafters, Pearl Vision, 1-800-Contacts, etc.

Please list any person(s), establishment(s), etc., you wish this office to share information on your behalf. If none, please write "NONE." _____

1.) _____
2.) _____
3.) _____
4.) _____
5.) _____

This list can be modified or changed at any time, but **MUST BE DONE SO in WRITING!!! All letters must be sent by certified mail and addressed to Dr. Cavallo.**

You, the undersigned, agree not to hold any agent of Dr. Joseph L. Cavallo, OD, PC, responsible for any harm which may arise from the release any information on your behalf.

Patient or Caretakers signature: _____ Date: _____

Office Policy regarding method of Information Dissemination:

Please note: Any information transmitted by FAX or E-Mail, whether it be to YOU directly or on your expressed behalf, i.e., to those you have authorized, cannot be guaranteed a secured portal of either transmittance or receivership.

Please initial, and date, if you accept such a condition. _____

In accordance with HIPPA, should you not agree to such a condition no information will be released, either, directly to you, or on your expressed behalf, by either Fax or E-Mail.

Name of Primary Medical Insurance: _____
Policyholder's name: _____ D.O.B.: _____ Social: _____

Name of Secondary Medical Insurance: _____
Policyholder's name: _____ D.O.B.: _____ Social: _____

Name of Tertiary Medical Insurance: _____
Policyholder's name: _____ D.O.B.: _____ Social: _____

Do you have Vision Service Plan? YES / NO. If yes, Name/Social/Relationship of Insured.
_____

Do you have Eye Med Insurance? YES / NO. If yes, Name/Social/Relationship of Insured.
_____

Do you have Davis Vision Insurance? YES / NO. If yes, Name/Social/Relationship of Insured.
_____

HMO Patients
All co-payments are to be paid prior to services rendered.
In accordance with your insurance company, failure to obtain your referral, if necessary, will nullify your contract. You will, therefore, be responsible for the full amount of the visit; and payment is expected at the conclusion of your visit.

Authorization to release information:
I hereby authorize Dr. Joseph L. Cavallo, OD, PC, to furnish the insured's insurance company all information which said insurance company may request concerning my claim.

Assignment of Benefits:
I hereby assign to Dr. Joseph L. Cavallo, OD, PC, all money which I am entitled for expenses related to the services performed from time to time, but not to exceed my indebtedness to said entity. It is understood that any money received from the above named insurance company or companies over and above my indebtedness will be refunded to me when my bill is paid in full.
I am financially responsible to said entity for charges. Should it become necessary the patient and/or responsible party agree to be personally liable for any interest, collectors cost, attorney fee and/or court costs incurred in the collection of any unpaid balance.

_____ _____
Patient Signature **Signature of Responsible Party**

Verified by: _____ Date: _____