

Medical Release, Lifetime Signature, Payment Authorization and HIPAA Acknowledgement

Patient Name: Mr. Mrs. Ms. Dr. _____

Responsible Party: _____ Referred By: _____

Street: _____ Phone: _____

City: _____ State: _____ Zip: _____ Mobile Phone: _____

Date of Birth: ___/___/___ Last Four of Social Security #: _____ E-Mail _____

Language: _____ Race _____ Ethnicity (Hispanic or Latino) _____

Occupation: _____ Employer: _____

Primary Medical Insurance: _____ Secondary Medical Insurance: _____

Vision Insurance: _____ Primary Medical Physician: _____

Preferred Method of Contact for Appointment Reminders and Office Communication

(Please check all that apply)

- Email** **Text** **Voice** **Mail**

Note: There are two types of Insurances that may help pay for your eye care services and products. You may have both, and our practice does accept both:

- Vision Care Plans**, such as VSP, Eyemed, VBA
- Medical Plans**, such as Medicare, BC/BS and Aetna, Horizon

Vision Care Plans cover only routine vision exams, along with eyeglasses and contact lenses. These plans do not cover diagnosis, management, or treatment of eye diseases.

Medical Plans must be used if you have an eye health problem or systemic problem that has ocular complications. The doctor will determine if these conditions apply to you. Many medical plans, such as Medicare, do not cover refraction, or the determination of a prescription for eyeglasses. This charge, as well as any other "non-covered" services and co-payments will be the responsibility of the patient.

I hereby give my consent for me or my child to be seen by the doctors. I understand that my eyes may be dilated during examinations. I acknowledge that I have read and agree to the Privacy Policy (HIPAA), and I also authorize the office of **Dale Stein and Associates, O.D., P.C** to share my demographic information with **SolutionReach** for the purpose of sending annual examination recall notices, and that copies of these policies are available on request. I also authorize payment and/or insurance benefits for services rendered by Dale Stein and Associates, O.D., P.C. be made payable to this office. ***I also understand that I am responsible for any non-covered services, co-payments and deductibles.***

Signature: _____ Date: ___/___/___