(FILL OUT THIS ENTIRE SIDE PLEASE)
Full Spectrum Family Vision Care

1224 Del Prado Blvd, S, Ste A Cape Coral, FL 33990

Welcome to Full Spectrum Family Vision Care. Thank you for choosing us for your eye care needs.

PATIENT INFORMATION

Patient Name: _____DOB: _____ Email:_____

Marital Status: _____ **PRIMARY CARE PHYSICIAN**_____

EMERGENCY CONTACT_____Phone:_____
Name/Relationship

Please list all the people, if any, with whom we have your permission to discuss your care.

1. _____ Relationship: _____

2. _____ Relationship: _____

**If you are new today, whom can we thank for referring you to our office?_____

Please complete ONLY if patient is a minor child under the age of 18:

Father's Name:_____ Mother's Name:_____

CONSENT OF RELEASE OF HEALTH INFORMATION & ASSIGNMENT OF BENEFITS

INSURANCE: I request that payment of authorized insurance benefits be made on my behalf to Full Spectrum Family Vision Care PA, for services furnished to me by Full Spectrum Family Vision Care PA. I authorize any holder of medical information about me to release to my insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. Full Spectrum Family Vision Care PA accepts the charge determination/fee schedule of the insurance carrier as the full charge, and **I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Insurance Carrier.**

RELEASE OF INFORMATION: Full Spectrum Family Vision Care may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Full Spectrum Family Vision Care for reimbursement for services rendered (such as the insurance carrier), and (2) any health care provider for continued patient care with signature. Full Spectrum Family Vision Care may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Full Spectrum Family Vision Care, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Full Spectrum Family Vision Care for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Full Spectrum Family Vision Care. **If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Full Spectrum Family Vision Care.** I understand that there are **NO REFUNDS for contact lens fittings or examination fees/copays. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.**

_____ _____

Authorized Signature Date

********HIPPA Notice of Privacy Practices:** I acknowledge I have read and/or received Full Spectrum Family Vision Care's Notice of Privacy Practices (see clipboard). **********

_____ _____

Authorized Signature Date

(SIGN BOTH AREAS PLEASE TO AUTHORIZE US TO BILL YOUR INSURANCE & TO ACKNOWLEGE THE PRIVACY POLICY)