Cutler Eye Care Get Acquainted Form

Patient Information:

_____ ____ _____Male___ Female___ _____/_____/_____

First Name MI Last Name Today's Date

_____

Street Address City State Zip Code

_____ _____ _____ _____

Date of Birth Social Security # Home Phone Work Phone

_____ _____

Place of Employment Occupation

Would you like to receive appointment reminders and information via text message or email? Yes____ No____

_____ _____

Email Address Cell Number

Primary Insurance Information: **(We must have a current copy of your insurance card and all information must be filled out or your insurance will not be billed. If the insured is under 18, then we must have the guardian's information below.)

_____ _____ _____

Name of Medical Insurance Name of Vision Insurance Insured's Name

_____ _____ Patient's Relationship to Insured: Self____ Spouse____ Child____ Other____

Insured's Date of Birth Insured's SSN# Patient's Status: Single ____ Married ____ Other____ Student ____ Employed____

_____ _____ _____

Guardian's Name Same as Insured ☐ Guardian's Date of Birth Guardian's SSN#

Responsibility Statement:

Your insurance is a method for you to receive reimbursement for fees you have paid James K Cutler & Associates, P.C., for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them and not with our office. It is your responsibility to pay in advance for the deductible, coinsurance, or any other balance not paid for by your insurance. We will assist you in receiving as much reimbursement as possible, however, you are responsible in advance for your bill. Examination fees and all copayments are due at the time of service. All products must be paid in full before they are ordered.

Financial Responsibility:

By signing this statement you agree to be financially responsible for all charges. If an account goes unpaid, a finance charge of 1.50% per month is applied to balances 60 days past due. A fee up to 33.33% is added to accounts sent out to Collections. All returned NSF checks will be charged a service fee of $25.

Authorization to Release Medical Information:

I authorize James K Cutler & Associates, P.C. to release/request medical information on my behalf to/from any entity to assist in my medical care per my request. I also authorize my insurance carrier to make payment directly to James K Cutler & Associates, P.C. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be as valid as the original.

HIPPA Acknowledgement (Copy Available in Lobby):

I acknowledge that I was provided the opportunity to receive/review a copy of the HIPPA Privacy Policy Notice.

_____ _____ _____

Patient or Guardian Signature **Relationship to Patient** **Date**