(PLEASE PRINT) **Patient Information** **(PLEASE PRINT)**

Please Circle
Male or Female Last Name: _____ First Name: _____ Middle Initial: _____

Single ☐ Married ☐ Widowed ☐ Divorced ☐ Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Mailing Address: *(If different from street)* _____

Social Security # _____ Occupation: _____

Ethnicity: Not Hispanic or Latino ☐ Hispanic or Latino ☐

Race: American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐

Native Hawaiian or Other Pacific Islander ☐ Caucasian ☐

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Primary Care Information: (if Diabetic please fill out this section so report can be sent to your doctor)

Primary Care Physician: _____ Physician Phone: _____

Referring Physician: _____ Physician Phone: _____

Preferred Pharmacy: _____ Pharmacy Location: _____

Pharmacy Phone: _____

Responsible Party Information: Complete this section ***ONLY IF*** the person responsible for payment is *different* than the patient.

Primary Name on Insurance: _____ Date of Birth: _____

Address: _____

Relationship: _____ Phone Number: _____

Emergency Contact Information:

Name: _____ Phone Number: _____

Alternate Phone Number: _____ Relationship: _____

I attest that all the above information is correct and accurate to the best of my knowledge. I authorize The Optometry Group, PLLC to contact me by any electronic method. If I wish to change any of my contact information, I understand it is my responsibility to contact The Optometry Group, PLLC and update my records. By signing below, I agree to each of the above statements for myself and/or on behalf of the Minor or Individual for which this information pertains. I have been informed and agree to the office policies listed on the back.

Patient Signature: _____ Date: _____

Office Policies

It is the mission of The Optometry Group to provide the best quality optometric and optical services to each patient, by focusing on their individual needs. We strive to enhance our patient's education, to help them better understand the components of eye and vision health.
Our doctor and clinical staff adhere to the highest ethical standards. We seek advanced education and technology to provide the best in quality and care for our patients. We strive to stay at the front of the eye care profession. We maintain an interactive care facility to develop relationships with our patients, so that our patients leave feeling like family and know that they are our priority.

Authorization to Release Information

May we leave messages regarding future appointments on your voice mail or email? Yes ☐ No ☐

I authorize The Optometry Group, PLLC to discuss my care and/or appointments with the following person(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Scheduling Notice

While we strive to schedule appointments appropriately, emergencies can and do occur in specialty medicine, and Dr. Hubbard will always give his patients the time they require. For this reason, we kindly request your patience and understanding should a delay or rescheduling be necessary on your appointment date.

Late Policies/No Show Policies

•In order to reduce wait time for our patients, we ask that you arrive 5-15 minutes early for your appointment. In addition, your appointment time is reserved specifically for you and in the event that you are unable to keep your appointment, we request enough time to make that appointment slot available to patients that are waiting to be seen. Please review the following policies that apply to ALL patients and ALL circumstances.
•**Late Policy**: Appointments may be rescheduled if you are more than 20 minutes late for your scheduled appointment time.
•**No Show Policy**: Appointments will be considered a "No Show" if you are more than 30 minutes late for your scheduled appointment time or you fail to show up. After you have accumulated 3 "No Shows" on your account, you will be seen as a walk-in patient only. If you would like to reset your "No Show" count, a non-insurance fee of **$50.00** will be charged to your account. After the fee has been paid, your count will be reset to "0". Should you incur an additional 3 "No Shows" you will revert back to a walk-in patient or you can pay the **$50.00** fee again.

Payment Policies

•In order to keep our costs and fees as low as possible we ask the all Co-Pays / Coinsurance / Deductible amounts be paid at the time of service. Once payment is received from your insurance company, we will send you a statement detailing any refund or balance owed.
•It is the patient's responsibility to know if Dr. Hubbard is a participating provider with their medical/visual policy. If we are not a participating provider your insurance company may not pay for some or all of the charges associated with your visit. Any remaining charges that are not paid by the insurance company will be the patient's responsibility.
•**ANY outstanding balances owed to The Optometry Group, PLLC must be paid in full before being seen. ANY office credits will be automatically used on ANY outstanding balances. ANY balances past 90 days will automatically be turned over to collections. You will then be responsible for: outstanding balance, collection fees and/or legal fees.**
•If a refund is owed: Office Credits will be issued in lieu of a refund check if the balance is $20.00 and under. If you prefer a refund check over an Office Credit, you must advise the Insurance Coordinator or Office Manager .

Information Release to Insurance Company

I hereby authorize The Optometry Group, PLLC to furnish information to insurance companies as may be requested for illness or injury. This authorization shall apply to my records or any minor listed above. I authorize the payment for these services to be made directly to The Optometry Group, PLLC.

Right To Refuse

Right to Refuse Treatment: In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.