ARMSTRONG OPTOMETRY & ASSOCIATES

Patient Registration Form

Patient Information

Legal First Name _____ Middle Initial ____ Last Name _____

Preferred Name _____

Date of Birth _____ Gender at Birth _____

Daytime Phone _____ Cell Phone _____

Street Address _____ Suite/Apt # _____

City _____ State _____ Zip Code _____

Email _____ Race _____

Ethnicity Hispanic Non-Hispanic Declined Preferred Language _____

Guardian Information ***(if patient is under 18 years of age)***

Legal First Name _____ Middle Initial ___ Last Name _____

Date of Birth _____ Relationship to Patient _____

Daytime Phone _____ Cell Phone _____

Street Address _____ Suite/Apt # _____

City _____ State _____ Zip Code _____

Email _____

Insured Person Information ***(policy holder)***

Legal First Name _____ Middle Initial ___ Last Name _____

Date of Birth _____ Relationship to Patient _____

Daytime Phone _____ Cell Phone _____

Street Address _____ Suite/Apt # _____

City _____ State _____ Zip Code _____

Email _____

Please initial

Financial Policy

Most insurance policies pay only a portion of your total charges. We do not guarantee the accuracy of benefit information given to us by insurance companies. Please understand that financial responsibility for your account is yours, not the responsibility of the insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or to myself if the provider does not accept assignment. I understand that I am responsible for any balance my insurance does not pay. Failure to pay outstanding balances may result in my account being turned over to a collection company and being dismissed from the practice.

_____ Yes, I understand the Financial Policy

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Please initial

Notice of Privacy Practices

A Notice of Privacy Practices is available for your review. This Notice describes our effort to protect the privacy of your personal health and financial information. It also describes how such information may be used, released, or shared. Copies are available upon request.

_____ Yes, I have read Armstrong Optometry's Notice of Privacy Practices and wish to continue my care.

_____ No, I have not read Armstrong Optometry's Notice of Privacy Practices but was given the opportunity to read it and declined.

Communication

This office may use texts and emails to communicate with you. Although HIPAA compliant, they may not be encrypted, and complete privacy cannot be guaranteed.

_____ Yes, I authorize the use of text and email.

Cell phone for texting _____ Email address _____

_____ No, I do not authorize the use of text and email to communicate with me.

No Show Policy

We schedule our appointments so that each patient receives dedicated time with our physicians and staff. It is important that you keep your scheduled appointment with us and arrive on time.

If your schedule changes and you cannot keep your appointment, we require at least 24 hours' notice. If you do not cancel or reschedule your appointment with at least 24 hours' notice, Armstrong Optometry and Associates may add a $50.00 "no-show" fee to your account. This fee is not reimbursable by your insurance company.

After three consecutive no-shows to your appointment, we reserve the right to dismiss you from the practice. I understand that no-show policy and agree to pay all fees before I can schedule another appointment.

We understand that there are extenuating circumstances that may prevent you from providing 24-hour notice. Please contact the Practice Administrator if this occurs.

_____ Yes, I understand the No Show Policy.

By signing this document, I have read and agree to the terms and conditions outlined above.

Patient/Parent Signature: _____ Date: _____

Staff Witness: _____ Date: _____