WELCOME TO FRANK EYE CENTER PATIENT INFORMATION 2026

Patient's Name _____
Last Suffix First Middle Initial Nickname

Address _____
Street Apt City State Zip Code

Date of Birth _____ Social Security Number _____ Sex: Male Female

Marital Status (circle): S M D W Email_____

Phone: Home_____ Cell_____ Work_____
(Circle preferred contact number)

Race_____ Ethnicity (circle): Hispanic/Latino Other Decline to answer.

Primary Language (circle): English Spanish Other _____

Primary Care Physician _____ Address_____

EMERGENCY INFORMATION
Contact Name_____ DOB: _____ Phone_____

PATIENT EMPLOYMENT INFORMATION
Employer_____ Occupation_____
Address_____ City_____ State_____ Zip_____

Is this a medical condition due to an accident? YES NO If yes, Date of Accident _____
How did you hear about us? Internet Friend/family Doctor Other_____

Release of Medical Information and Statement of Notice of Privacy Practices
I hereby authorize Frank Eye Center to release my insurance or any other third-party payer any and all information necessary to process a claim on my behalf. I authorize my insurance to assign my benefits directly to Frank Eye Center. Your medical information is personal to you by law and Frank Eye Center is required to make sure it is kept private. You may obtain a copy of our privacy policy by request.

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments; however, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered, unless other arrangements have been made in advance.

AUTHORIZATION: I request that payment of authorized Medicare/other insurance company benefits be made either to me or on my behalf to Frank Eye Center, P.A. for any services furnished to me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid services or its intermediaries or carriers any information needed for this or related to a Medicare/other insurance company claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the healthcare provider or any other party that may be responsible for paying for my treatment.

Patient Signature_____ Date_____ Or signature of parent or legal guardian if patient is under 18 years of age. Patients under 18 must have a parent/guardian present at exam OR written consent/Minor Consent Form.

FRANK EYE CENTER FINANCIAL POLICY 2026

Patient Name _____ Date of Birth _____

Insurance Coverage: It is your responsibility to provide our office with accurate information for billing your insurance at the time of service. It is also your responsibility to know if your visit is covered by your primary insurance plan fully, partially, or not at all. For example, you may be covered under your primary healthcare plan and for additional vision services under a different carrier. It is your responsibility to know if you have separate coverage. If, at time of service, you do not provide us with your current coverage and late make us aware of additional coverage you will be responsible for any and all charges. We will gladly provide you with an itemized receipt to submit to your insurance for reimbursement. Information of this type is only 100% accurate if you obtain it directly from your health plan. In the event you do not confirm this information and the insurer refuses full or partial payment, you will be responsible for the cost of services provided.

Medical Insurance Information:

Primary _____
Insurance **Name of Insured** **Insured Date of Birth**

Secondary _____
Insurance **Name of Insured** **Insured Date of Birth**

Vision _____
Insurance **Name of Insured** **Insured Date of Birth**

Glasses and Contact Lens Exams
Exams for glasses and contact lens are separate exams. If you desire both exams on your visit, you will be charged a contact lens fitting fee of $45.00. Contact lens fitting fees may not be covered under your insurance plan. We require this fee to be paid at the time of service.

Amounts Due from Patient
Insurance co-payments will be collected at the time of service. If we do not participate with your insurance plan, you are to provide full payment at the time of service. If you are using insurance, we will make every effort to collect full and accurate fees specific to your plan. However, if there is a fee that your insurance charges and we did not collect it at the time the order was placed it must be paid in full before the glasses or contacts will be dispensed.

Amounts Determined "Not Covered"
In the event a health plan determines a service to be "not covered", you will be responsible for the complete charge. An example of this is the refraction. A refraction is a test to obtain your best corrected vision, to determine the need for glasses, surgery, and/or medicine. Most medical insurance plans, including Medicare, do not cover refractions. Our office will collect the refraction fee of $35.00 and any co-payments at time of service.

I have read and understand the financial policies of Frank Eye Center.

_____ _____
Signature of Patient (or responsible party) **Date**