Griswold Eye Care

Welcome Back! Thank you for taking the time fill out this form to make sure our records are as up to date!

___Mr. ___Mrs. ____ Ms. ____Other:_____ Preferred Pronouns: He/Him She/Her They/Them Other:_____

_____ _____ _____ _____
First Name MI Last Name Preferred Name

_____ _____ _____ _____
Street Address City State Zip Code

_____ _____ _____ Texting? **YES** / **NO**
Social Security Number Date of Birth Primary Phone Number

_____ _____
Email Address Other Phone Number (optional)

_____ I consent to my glasses and/or contact lens **prescription** being e-mailed to me if I request it and I
Initials
acknowledge it is **not HIPAA compliant**.

Emergency Contact: _____ Relationship: _____ Phone:_____

HAVE YOU HAD THE COVID-19 VACCINE? YES NO Sign_____

Changes to Medications (if applicable): _____

_____

Other Changes: _____

_____

HIPAA POLICY: Please read carefully.
I agree to allow my medical information be shared with my insurance company for the sole purpose of billing and to any healthcare provider necessary for continuity of care.
I acknowledge that I am aware that Griswold Eye Care has a notice of privacy practices available to me at all times during normal business hours. I fully understand that I am protected under HIPAA and will be required to sign a release for any and all medical records.

_____ _____
Signature of Patient/Legal Guardian Date

OFFICE POLICY: Please read carefully.
In order to control the cost of billing we require that the patient's portion of costs is due at the time of services rendered unless other arrangements are made in advance. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. All accounts with unpaid bills after 90 days are subject to collection fees. There will be a service charge on all returned checks. We require at least 24 hours notice for any cancelations or rescheduled appointments in order to be fair to our other patients. **Any late cancellations or missed appointments are subject to a $50 fee.** I acknowledge and accept the above policies.

_____ _____
Signature of Patient/Legal Guardian Date

Updated 01/01/2021