Patient Information

Name: _____
First M.I. Last Preferred Name

Address:_____
Street Apt# City/State/Zip

Preferred Phone Number: _____ Home☐ Cell ☐ Work☐

Appt/Order Notifications: Call ☐ Text ☐ Email ☐ **Sex:** M / F **Gender:** _____

Date of Birth: _____ **Email:**_____

Occupation/Student:_____ **Employer/School:**_____

Primary Care Physician: _____
Name Location/Phone Number

Pharmacy: _____
Name Location/Phone Number

Cancellation Policy: We require 24-hour notice to cancel or reschedule appointments. Failure to do so will result in a $25.00 fee that will be added to your account. This is not payable by insurance.

Payment for Services: Payment is due at the time services are rendered. You will be billed for any amounts not covered by insurance. If you DO NOT disclose your insurance benefits to us at the time of your visit, and you later discover that you have benefits, you can submit a claim to your insurance company on your own. No refunds will be issued.

Eyewear: All eyewear is custom ordered to meet our patients' specific needs. **All sales are final and non-refundable.**

Retinal Imaging: Our doctors have added Optomap Retinal Imaging to their ROUTINE exam protocol. **Optomap will be performed on ALL patients every 2 years.**Optomap is a wide-angle scan of the back of the eye which provides more information about eye health and helps to assess risk for eye disease and systemic disease. Our doctors will show you these retina scans during your visit and will also discuss any pertinent findings. **Optomap is NOT covered by insurance. The fee is $39.**

HIPAA Acknowledgement: I hearby acknowledge that I have been given the opportunity to read/or receive a copy of the Notice of Privacy Practices for Cicero family Eye Care (located at the front desk), which describes how my protected health information may or may not be used.

I consent to have Dr. Cutre and staff use and disclose my protected health information for submitting claims to insurance companies for payment of services rendered here, for coordination of my health care, or other purposes permitted per HIPAA or other federal and state laws.

Patient or Guardian Signature: _____ **Date:** _____

Please provide us with who we may disclose information to regarding your appointment.

Name: _____ Relationship: _____

Name: _____ Relationship: _____