Holicki Eye Centers and Holicki Optical
Patient Information

Last Name: _____ **Occupation: _____**

First Name: _____ **Employer: _____ / Retired**

Address: _____ **Work Phone: ( ) _____**

City: _____ State _____ Zip _____

Social Security # _____/_____/_____

Date of Birth: _____/_____/_____ **(Picture ID)**

Marital Status: S M W D **Gender: M F**

Home Phone: ( ) _____

Cell Phone: ( ) _____

E-Mail: _____

Emergency Contact: Name _____Relationship: _____ Phone: ( )_____

Primary Care Doctor: _____ Phone: ( ) _____ Pharmacy Used: _____

CARD HOLDER OR RESPONSIBLE PARTY, IF OTHER THAN PATIENT

Name: _____ Social Security #: _____/_____/_____ Date of Birth _____/_____/_____

Relationship to Patient: _____ **Employer: _____**

Address: _____ **Address: _____**

City _____ State _____ Zip _____ **City _____ State _____ Zip _____**

Home Phone ( ) _____ **Work Phone ( ) _____**

Occasionally, on your behalf and with your permission, it is necessary for us to disclose or share your Protected Health Information with another person/s. Please specify the individual/s None □

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Payment Policy:

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to the Physician / Provider for the medical or ophthalmic benefits provided, if any.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the providing Physician to release any information required in the course of my examination, treatment, or purchase of glasses or contact lenses and special order retail items and allow a photocopy of my signature to be used in processing my claim.

PAYMENT POLICY, Holicki Eye Centers and Holicki Optical: Insurance Co-Pay is due AT THE TIME OF SERVICE. If you do not know what your co-pay is, the charge will be $20.00. Once the insurance company pays, we will either bill you if it is more, or refund you if it is less. Unpaid balances more than 90 days old will be sent to collections. If an account must be sent to collections, the collection fee will be up to 50% of the balance due, but not more than the fee charged by the collection company.

****** All items ordered are considered special orders and are non-refundable

****** We reserve the right, at our discretion, to charge patients a fee of $25.00 for not keeping their appointments.

****** Returned check fee for Holicki Eye Centers and / or Holicki Optical is $35.00

PATIENT PRIVACY PRACTICES (HIPAA): I acknowledge that I have been offered a copy of the Notice of Privacy Practices for Holicki Eye Centers and Holicki Optical. It provides information about how we may use and disclose protected health information about you. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996.

My Signature serves as a "signature on file" for claims processing and for release of information to my insurance carrier. This signature also gives my permission to allow in the transfer of information between Holicki Eye Centers, P.C. and Holicki Optical, Inc. This signature also gives us your consent to use and disclose protected health information about you for your treatment, payment and health care operations.

Signed (Patient or responsible Party)_____ Date _____/_____/_____