TRI-CENTURY EYE CARE

Cosmetic Patient Intake Form

Title: _____ First Name: _____ Last Name: _____

Date of Birth (DOB): ____/____/_____ Gender: _____

Address: _____

_____

Home Phone: _____

Cell Phone: _____

Day Phone: _____

Email address: _____

Race: _____ Preferred Language: _____ Ethnicity: □ Hispanic/Latino □ Non-Hispanic/Latino

Emergency Contact: _____ Phone: _____ Relationship: _____

Primary Care Physician: _____

By signing this PATIENT CONSENT AND DISCLOSURE AUTHORIZATION, the patient or legal guardian of a minor patient understands and acknowledges that Tri-Century Eye Care, PC is committed to securing the privacy of health information. Accordingly, we have posted our **Notice of Privacy Practices** in our offices and the patient has been provided the opportunity to take a copy.

The HIPAA Privacy Rule gives the individual the right to request the release of Protected Health Information (PHI) to identified individuals.

I authorize my PHI to be disclosed to the following individuals only:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____ _____

Print Patient Name Patient Signature Date

COSMETIC SELF-PAY FINANCIAL POLICY

Revised January 25, 2021

Thank you for choosing **Tri-Century Eye Care** as your health care provider. We are committed to building a successful relationship with you. Your clear understanding of our Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. You are asked to sign this acknowledgement stating you have read and agree to our Financial Policy prior to services being rendered.

We will collect payments for all services at the time of service.

Outstanding Balances and Collection:

We accept cash, personal checks, and credit cards. All payments are expected at the time of service. **All outstanding balances are due upon receipt of the first statement and must be paid in full prior to receiving additional services or materials.** 30 days from the date of service, interest fees up to 15% per month may be applied to each unpaid encounter. There may be a fee up to $40.00 for checks returned by your bank. You may receive a delinquent letter if your balance is not paid in 60 days. Unpaid balances over 60 days may be sent to a collection agency and may incur additional collection and processing fees up to 33%.

I have read the Financial Policy of Tri-Century Eye Care, PC and agree to the terms set forth herein.

_____	_____	_____
Print Name	Signature	Date