Thermopolis EyeCare LLC
420 Arapahoe Street
Thermopolis WY 82443

PATIENT INFORMATION

New ___ Update___ Doctor:_____________ Pt. #________

Patient's Legal Name____ Today's Date_____________

Address ____Zip Code ___________ Home Phone ______________
(Leave Message? **Y / N**)

Sex_______ Age _______ D.O.B. __________________ SS# ____________________ Work Phone________________
(Leave Message? **Y / N**)

Marital Status _______________ Employment Status ____________________________ Cell Phone _________________
(Leave Message? **Y / N**)

Employer's Name ____________________________ Email Address____

Spouse Name____Home Phone ______________

Spouse Address (if different)____Cell Phone _________________

Patient's Emergency Contact:_____________________________ D.O.B. _____________ Phone_____________________

Emergency Contact Relation to Patient: ____

Patient's Pharmacy/Location:____

Patient's Primary Care Physician ______________________ Patient's Referring Doctor: __________________________

PARENT INFO IF PATIENT IS UNDER 18 YEARS OF AGE:

Father's Name:_________________________________ Father's Social Security Number:__________________________

Father's Phone Number:__________________________ Father's Employer:_____________________________________

Mother's Name:________________________________ Mother's Social Security Number:_________________________

Mother's Phone Number:_________________________ Mother's Employer:_____________________________________

DO YOU HAVE INSURANCE? Yes ___ No ___ If Yes, Name of Carrier:_______________________ID#_____________
Insurance Card Holder Name _________________________________ Social # of Card Holder:_____________________
Home Phone Number ____________________ D.O.B. _________________ Relation to Patient ____________________
Home Address ____

SECONDARY INSURANCE? Yes ___ No ___ If Yes, Name of Carrier _______________________ID#____________
Insurance Card Holder Name __________________________________ Social # of Card Holder: ____________________
Home Phone Number ____________________ D.O.B. _________________ Relation to Patient ____________________
Home Address ____

Thermopolis EyeCare is committed to providing the best treatment possible for our patients at rates that are usual and customary for our area. You are responsible for payment in full regardless of the interpretation of what is "usual and customary" by a given insurance company.

PAYMENT IS EXPECTED AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS ARE MADE
ALL APPOINTMENTS NOT CANCELLED WITHIN 24 HOURS OR NO SHOWS ARE SUBJECT TO A $50.00 FEE

NEAREST RELATIVE *NOT* LIVING WITH YOU

NAME____ RELATIONSHIP _________________

ADDRESS ____ PHONE _________________________

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Signatures Required on Reverse Side

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a Notice of Privacy Practices of **Thermopolis EyeCare**. I understand that my Protected Health Information (PHI) may be used and disclosed for the purposes of TREATMENT, PAYMENT and HEALTHCARE OPERATION of the practice.

WRITTEN AUTHORIZATION FOR RELEASE OF PHI

I hereby authorize **Thermopolis EyeCare** to discuss my Protected Health Information (PHI) with the following person(s). Should I wish to revoke this authorization I understand I must do so in **WRITING**.

Name____Relationship_____________________________

Phone Number_________________________________

Name____Relationship_____________________________

Phone Number_________________________________

Name____Relationship_____________________________

Phone Number_________________________________

Name____Relationship_____________________________

Phone Number_________________________________

CONSENT TO ASSIGNMENT OF BENEFITS AND PROMISE TO PAY

Benefits to Physicians:
I hereby assign all of my rights to insurance benefits and instruct my insurance company to make payments directly to **Thermopolis EyeCare** and/or its physicians for the benefits provided.

Promise to Pay:
I understand and agree that I am responsible to pay for all services provided to me by **Thermopolis EyeCare** and its staff. If I fail to pay for the services when they are rendered or on a signed agreed payment schedule, I will be responsible for all costs of collection, including but not limited to, interest at the rate of one and a half percent (1.5%) per month or eighteen percent (18%) per year, court costs and fees, attorney fees, and a collection fee of thirty five percent (35%) of the unpaid balance assigned for collection.

_____________________________ ____
Date Patient Signature

____________________________________ ____
Signature of the Patient Representative Relationship
(Required if the patient is a minor or an adult unable to sign)