Welcome to . Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name MI Last Name Preferred Name

Street Address City State Zip

Social Security Number Date of Birth Home Phone - Include Area Code Day Phone

Email Address Guardian Person Responsible for Account

Emergency Contact Emergency Phone

How were you referred to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient

☐ Insurance Listing ☐ Drive by ☐ Other ☐ Doctor

Who were you referred by?

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company City State Zip

M ☐ F ☐ Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status ☐ Single ☐ Married ☐ Other

☐ Full Time Student ☐ Part Time Student ☐ Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company City State Zip

M ☐ F ☐ Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient.The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature Date

Please Read and Sign Both Parts

1. Acknowledgment of Receipt:

I acknowledge that I received a copy of Dr. David Dalesio's Notice of Privacy Practices.

Print Patient Name: ______________________________ Date: ___________

RESPONSIBLE PARTY SIGNATURE: ____

2. Insurance Payments:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. 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. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to Fort Myers Eye Associates, PA. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that the final determination can only be made when the claim is processed.

RESPONSIBLE PARTY SIGNATURE: ____________________________________

Date: ___________

FORT MYERS EYE ASSOCIATES HIPPA RELEASE FORM

Patient Name: ________________________________ ID#________________

HIPPA privacy regulations require our office to have a release signed by our patient's so we may speak with family members, friends and others regarding your medical treatment, history, appointments and financial information. Each person you wish to be considered a contact **MUST** be listed individually by name (including a Spouse or Significant Other).

Please print names, relationship and telephone number for each person to whom you are authorizing release of your private health care information and financial information.

Name: ______________________ Relation: ________________ Ph#____________

Name: ______________________ Relation: ________________ Ph#____________

Name: ______________________ Relation: ________________ Ph#____________

Name: ______________________ Relation: ________________ Ph#____________

This authorization will expire on: _____/_____/_____ (fill in date if request is for less than one year) or valid for one year after being signed.

Patient Signature: ____________________________ Date: ____________________