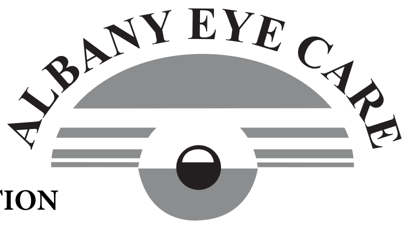


Brian Pieper, O.D.

Nikalous Tolman, O.D.

aec@albanyeyecare.net

## PATIENT INFORMATION

**Today's Date** _____/_____/_____

Patient's Name ______________________________ Date of Birth____________ SSN ____________
First M.I. Last Month/Day/Year

Patient's Address ______________________________ ____________ ________ ________
Street/Apt # City State Zip

Telephone ______________ ______________ Gender: M F Occupation:______________
Home/Cell Work

Employer: ______________________ Employer's Address: ______________________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ______________________
Have we seen any other members of your family? If so, please list them above.

Email ______________________ Is the cell number OK for texting: Y N

## PARENT INFORMATION (If patient is under 18 or parent is the responsible party)

**Father's Name** ______________________________ Date of Birth____________ SSN ____________
First M.I. Last Month/Day/Year

Address (if different)______________________________ ____________ ________ ________
Street/Apt # City State Zip

Telephone ______________ ______________ Employer: ______________________
Home/Cell Work

**Mother's Name** ______________________________ Date of Birth____________ SSN ____________
First M.I. Last Month/Day/Year

Address (if different)______________________________ ____________ ________ ________
Street/Apt # City State Zip

Telephone ______________ ______________ Employer: ______________________
Home/Cell Work

## SPOUSE INFORMATION

Spouse's Name ______________________________ Date of Birth____________ SSN ____________
First M.I. Last Month/Day/Year

Telephone ______________ ______________ Employer: ______________________
Home/Cell Work

## INSURANCE INFORMATION

**Primary** Carrier: ______________________ ID # : ______________________ Group ID: ______________

Policy Holder's Name ______________________________ Date of Birth____________SSN ____________
First M.I. Last Month/Day/Year

Policy Holder's Address______________________________ ____________ ________ ________
Street/Apt # City State Zip

Type of Coverage: ☐ Medical ☐ Vision Employer: ______________________ Relationship to Patient: ______________

**Secondary** Carrier: ______________________ ID # : ______________________ Group ID: ______________

Policy Holder's Name ______________________________ Date of Birth____________SSN ____________
First M.I. Last Month/Day/Year

Policy Holder's Address______________________________ ____________ ________ ________
Street/Apt # City State Zip

Type of Coverage: ☐ Medical ☐ Vision Employer: ______________________ Relationship to Patient: ______________

**ALL COPAYS, COINSURANCES, AND PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE UNLESS OTHERWISE ARRANGED!**

**PLEASE COMPLETE BOTH SIDES**

## ADDITIONAL INFORMATION

Primary purpose for this visit? ____________________

Any problems with your current glasses or contacts? ____________________

Do you work at computers for a long period of time? ____________________

Primary Care Physician: ____________________ Pharmacy: ____________________

Referring Doctor: ____________________ Reason: ____________________

How did you hear about our office? ____________________

**Please circle all that apply:**

Preferred method of communication: Telephone Email Text Message

Preferred Language: English Spanish Other: ____________________

Race: White American Indian Asian African American Hispanic Native Hawaiian Decline to Answer

Ethnicity: Hispanic/ Latino Not Hispanic/ Latino Native Hawaiian Decline to Answer

## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been offered, received or reviewed a Notice of Privacy Practices for Albany Eye Care. I understand that my protected health information (PHI) may be used and diclosed for the purposes of **TREATMENT**, **PAYMENT**, and **HEALTHCARE OPERATIONS** of the practice.

____________________ Date

____________________ Patient Signature/Legal Guardian or Representative

## CONSENT TO ASSIGNMENT OF BENEFITS AND PAYMENT AGREEMENT

I request that payment of authorized insurance benefits for my insurance company(s) be made on my behalf to Everett L. King, O.D. or Brian Pieper, O.D. for any services or materials rendered. I authorize any holder of medical information about me to release any information needed to determine these benefits for the purposes of treatment and billing. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance(s).

I understand and agree that I am responsible to pay for all services and materials provided to me by Albany Eye Care and its staff. **PAYMENT IS EXPECTED FROM ME AT THE TIME OF SERVICE FOR ANY CO-PAYMENTS, COINSURANCES, OR PORTIONS OF CHARGES NOT COVERED.**

If I do not have insurance, payment in full is expected at the time of service. If I fail to pay for the services or materials rendered to me within sixty (60) days, I will be repsonsible for all costs of collection, including but not limited to, interest at the rate of five dollars ($5.00) per month, 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/Legal Guardian or Representative

FOR YOUR CONVIENCE WE ACCEPT CASH, CHECK, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, AND CARECREDIT!