James W. Andrews, O.D.
5062 Mobile Hwy., Pensacola, FL 32506
Patient Registration
(Please use black or blue ink)

Mr./Mrs./Ms./Miss/Dr._____ Nickname_____
Address_____
City_____ State_____ Zip_____
Home_____ Cell_____ Work_____
Male__ Female__ Married__ Single__ Other__ Birthdate_____ Age___
SSN_____ E-Mail_____
Employer_____ Occupation_____

Responsible party for the financial aspect (if over 18 list self and sign):
Mr./Mrs./Ms./Dr._____ Relationship_____
Address/City/ST/Zip_____
SSN_____ Birthdate_____ Phone_____
Signature_____ Date_____

Vision Insurance Policy Holder Information: Ins. Name _____
Mr./Mrs./Ms./Dr._____ Relationship_____
Address/City/ST/Zip_____
SSN_____ Birthdate_____ Phone_____

Primary Medical Ins. Policy Holder Info:Ins. Name_____
Mr./Mrs./Ms./Dr._____ Relationship_____
Address/City/ST/Zip_____
SSN_____ Birthdate_____ Phone_____

Secondary Medical Ins. Policy Holder Info: Ins. Name_____
Mr./Mrs./Ms./Dr._____ Relationship_____
Address/City/ST/Zip_____
SSN_____ Birthdate_____ Phone_____

Emergency Contact: _____

Signature on File
I request that payment of authorized Medicare benefits or other insurance be made either to me or on my behalf to Dr. Andrews for any services provided. I authorize the release of medical information to my insurance companies. I understand I am responsible for any charges not covered by my insurance. I permit a copy of this authorization to be used in place of the original.

Signature_____ Date_____

HIPAA Privacy Policy

In plain language, up to this point, it was assumed that when a patient sought a doctor's care, pertinent medical record information could be shared with other health care professionals joining in the care of the patient. In addition, when the patient presented a health insurance card for payment, the office would be able to provide all pertinent information related to the claim to fulfill the transaction. With these new government regulations, that is no longer the case. Patients are not obligated to sign these privacy consent/authorization forms, however, when they do so, we can comply with the new law and continue to provide our patients with the care and service they expect.

Please provide us with a list of people you would like to have access to your records (OPTIONAL):

_____

_____

_____

I acknowledge that I have reviewed a copy of Dr. Andrews' Notice of Privacy Practices:

Patient Name: _____ Date: _____

Signature of Patient/Guardian: _____

James W. Andrews, O.D.

5062 Mobile Highway
Pensacola, FL 32506
(850) 453-4373

Financial Policy

Our Policy is to provide exceptional health care services. We have agreements with most insurance payers and with those agreements we bill in accordance with the terms of the contracts. We assure you that the charges accurately reflect the complexity of care rendered and the skill and expertise required for your care.

Insurance Policy:
All insurance information must be shown at each appointment or you could be responsible for the entire amount of the office visit and/or procedures. You are responsible to know what insurance you have and what that insurance covers. Insurance is not a guarantee of payment and you will be responsible for anything not covered.

If you are a member of an HMO plan that we accept then you will be responsible to make sure we have a referral from your PCP before your appointment. If we do not have a referral you will either have to reschedule or be responsible for all office visit and/or procedures accrued.

Payment:
We accept Visa, MasterCard, Discover, American Express, checks, cash and Care Credit.

We do require payment of office visit and/or procedures, co-payments, deductibles and payment of glasses and/or contacts in full at the time of services. If there is a balance owed after all insurances have been filed a bill will be sent unless it is below $10.00. Those balances will be owed at your next visit.

A $30.00 returned check fee will be charged to any returned checks.

Refunds:
Refund checks are sent only if the amount is $25.00 or more. Anything less will be added as a credit on your account for your next visit.

Collections:
If a balance of $50.00 or more has been on your account for more than 120 days then that balance will be sent to a collection agency unless prior arrangements have been made. If a balance is sent to collections you will be responsible for any additional charges incurred by the collection agency.

_____ _____ _____

Patient Printed Name Patient/Guardian Signed Name Date

Scanned and Copy Given to patient_____