Welcome to Rolling Hills Eyecare

Please take a moment to read and complete this form. Thank you.

Last name____First
____MI________Birthdate_________________
Address (if changed)____
City ____ State _____________ Zip ____________
Phone (home)____ (work) ______________________________ (cell)
____
Email: ____ (please print clearly)

Policies and Notifications

Notice of Privacy Practices – Acknowledgement of Receipt

Rolling Hills Eyecare is required to protect the privacy of your health information as described in the Notice of Privacy Practices (NPP). Copies of the NPP are available in-office and on our website www.rollinghillseyecare.com.

I acknowledge that I had the opportunity to review and/or receive a copy of Rolling Hills Eyecare's Notice of Privacy Practices.

Patient name ____ Legal guardian name
____
Signature ____ Date _____________________

Financial Policy Agreement

I understand that any services and materials will be billed to my insurance company(s) if I have provided proof of insurance coverage at the time the services are rendered or materials are provided. I understand that I am responsible to promptly pay any portion not covered by my insurance at the time services or materials are provided or at the time I am notified of a balance by my insurance company or Rolling Hills Eyecare.

Patient name ____ Legal guardian name
____
Signature ____ Date _____________________

Communication Preference

By what method would you prefer us to contact you for appointment confirmations, glasses or CL ready notifications etc?

√ Text √ email √ Text and email √ I don't use text or email, please contact me by phone (√ home √ work √ cell)

May we send you a postcard in the mail when it is time for your next annual vision & eye health exam?

√ Yes √ No

I understand that texting and regular email are not secure methods of communication. Rolling Hills Eyecare will send only the minimal information needed to notify me and will NOT send any medical information via these methods unless I specifically request they do so. I understand it is my responsibility to reduce exposure of messages on my devices and that, depending on my phone carrier, I may be charged for the text messages. I may cancel this authorization at any time.

Patient name ____ Legal guardian name
____
Signature ____ Date _____________________