Welcome to Rolling Hills Eyecare

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

Last name_____First _____MI_____Birthdate_____
If patient under 18 yrs: Legal Guardian name _____
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 or legal guardian 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 or legal guardian 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 in writing that they do so. I may cancel this authorization at any time.

Patient or legal guardian signature _____ Date _____

OPTIONAL: If you would like to allow a family member to call on your behalf and verbally receive medical or financial information, please indicate that person below:

_____ _____
Name of family member (please print) Relationship