Patient Registration

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Mx.

Legal Name (Last, First): _____ **Middle Name:** _____

Name Preference: _____ **Parent(s)/Guardian(s):** _____

DOB: _____ **Sex:** ☐ **Male** ☐ **Female** ☐ **Rather Not Disclose** **Preferred Pronoun:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Preferred Phone # _____ ☐ **Cell** ☐ **Home** ☐ **Work** **Email:** _____

I would prefer NOT to receive text/email notifications ☐ **SSN:** _____ (for insurance purposes only)

Employer: _____ **Occupation:** _____

****IF YOU HAVE ADDITIONAL COVERAGE BEYOND WHAT'S NOTED, PLEASE NOTIFY A STAFF MEMBER****

Primary Vision Insurance: _____ ID: _____

Primary Insurance Holders Name**:** _____ DOB _____

Relationship to Patient: _____ SSN (if not self): _____

Medical Insurance: _____ ID: _____

Primary Insurance Holders Name**:** _____ DOB _____

Relationship to Patient: _____

OFFICE POLICIES:

- **The evaluation of contact lenses is not included in the comprehensive exam. An additional charge will be issued for this service.** Fees for services (fitting, evaluation, and training) for soft contact lenses range from $30-$120. Evaluation for specialty and therapeutic contact lenses vary depending on complexity.
- All contact lens orders must be paid in full at time of order. All eyewear orders require a minimum deposit of 50% before the order can be processed. Eyeglass lenses are custom made and cannot be refunded. However, remakes may be necessary to finalize your prescription. One remake will be done free of charge if done within 60 days of dispensing.
- Queen Anne Eye Clinic will file insurance claims and await payment from your insurance company, but we cannot guarantee coverage by your insurance company, and you are ultimately responsible for any balances incurred. We will send you a statement if a balance remains, which is due within 30 days of notification. If payment is not received after 90 days, your account will accrue a 1% finance charge every month until payment is made. A $25 fee will be assessed for all returned checks.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our front desk.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. *A digital copy of this notice is available on our website, www.qaeye.com.

By my signature below, I acknowledge receipt of the notice of Privacy Practices & Office Policies. This will be retained in your medical record.

Signature _____ Date _____

Optomap Consent (more information about this scan is available at the front desk)

I elect to have Optomap Wide-Field Retinal Scan performed as part of my eye health exam _____

I elect **not** to have Optomap Wide-Field Retinal Scan performed as part of my eye health exam _____

****You may leave Optomap choice blank if you have further questions****

How did you hear about us?: Insurance List / Yelp / Search Engine / Sign / Friend or Relative / Doctor / Returning Patient

Who may we thank for the referral? _____