# Welcome to Picard Family Optical

Your New Home For Fashion Eyewear and Professional Service

# Dr. Dennis M. Picard, Optometrist

Today's Date ____________________

**Patient Information**

Last Name ____________ First Name ____________ MI ______

Address ____________________

City ____________ State ______ Zip ______

Email ____________________

Call me on my: ☐ Work Phone: ____________________

(Please list all phone #'s) ☐ Home Phone: ____________________

☐ Cell Phone: ____________________

Date of Birth ____________ Sex: M F

Marital Status: ☐ Single ☐ Married ☐ Other

☐ Employed ☐ Retired ☐ Full Time Studen ☐ Part Time Student

Occupation ____________________

Employer ____________________

Address ____________________

How did you hear about us?

☐ Previous patient of Dr. Picard ☐ Sign ☐ Church paper

☐ Internet ☐ Radio ad ☐ Yellow Pages

☐ Referred by: ____________________

☐ Other:

Emergency Contact Name ____________________

Phone Number

**Notice of Privacy Practices Acknowledgement of Receipt**

I have received this office's notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice on request.

____________________
Signature

____________________
Relationship to patient

**Billing and Insurance Information**

Person responsible for payment ____________________

Relationship to Patient ____________________

SS #

Primary Vision Insurance Co. ____________________

Subscriber Name ____________________

Date of Birth ____________________

SS # / ID#

Secondary Vision Insurance Co. ____________________

Subscriber Name ____________________

Date of Birth ____________________

SS # / ID#

Primary Medical Insurance Co. ____________________

Subscriber Name ____________________

Date of Birth ____________________

SS # / ID#

Secondary Medical Insurance Co. ____________________

Subscriber Name ____________________

Date of Birth ____________________

SS # / ID#

**Assignment and Release**

I, the undersigned, assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. I hereby authorize the doctor to release all information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party Date

**Disclaimer**

As a courtesy to our patients, we are pleased to accept insurance assignment. However, it must be clearly understood that the "contract" is between you, the patient, and your insurance company. You are thereby responsible for your account and any amount not paid by your insurance company.

**Contact Lens Fittings**

All follow up visits required to finalize your contact lens prescription are included in your contact lens fitting fee. You are required to make and keep any follow up appointments necessary to finalize your prescription. If you fail to schedule or show up for your follow up appointments, then after 30 days you may be charged for your appointments. Appointments for medical eye problems, such as an infection, are not included in the contact lens fitting fee and will be charged separately.