Ronald E. Dachelet, OD, FAAO
Optometrist

Dawn Dachelet Wilczek, OD
Optometrist

Please fill out ALL information.

PERSONAL INFORMATION

DATE__________ DATE OF BIRTH_____/_____/_____ AGE ________ SS# ____________________ MARITAL STATUS: S M W D

NAME ☐ DR. ☐ MR. ☐ MRS. ☐ MS. ____ Sex: M F
FIRST MIDDLE LAST

HOME ADDRESS ______________________________ CITY/STATE ____________________ ZIP __________

HOME# ______________ WORK PHONE# ______________ CELL PHONE# ______________ DRIVERS LICENSE# ______________

EMAIL ______________________________ MAY WE EMAIL YOU? ______________________________

SPOUSE/GUARDIAN (IF UNDER 18) ______________________ DOB ____________ RELATIONSHIP ____________

WHO IS YOUR PRIMARY CARE PHYSICIAN? ______________________________ PHONE # ______________

WHOM SHOULD WE THANK FOR YOUR REFERRAL? ______________________________

HOW DID YOU FIND OUT ABOUT ANNISTON EYE CLINIC? ☐ YELLOW PAGES ☐ INSURANCE ☐ WEBSITE ☐ FAMILY ☐ FRIEND ☐ PHYSICIAN

ACCOUNT RESPONSIBLE

IF DIFFERENT FROM ABOVE

PERSON RESPONSIBLE FOR ACCOUNT ______________________________

RELATIONSHIP TO PATIENT ______________ DATE OF BIRTH _____/_____/_____ SS # ______________

ADDRESS (IF DIFFERENT FROM PATIENT) ____
FIRST MIDDLE LAST

CITY ______________________ STATE ________ ZIP __________ PREFERRED PHONE # ______________

HEALTH INSURANCE INFORMATION

SOME EYE PROBLEMS ARE COVERED BY YOUR HEALTH INSURANCE

PRIMARY INSURANCE ______________________ CONT/ID # ______________________ GROUP # __________

PERSON INSURED ______________________ DATE OF BIRTH _____/_____/_____ RELATIONSHIP TO PATIENT ______________

EMPLOYER ____ PHONE # ______________

SECONDARY INSURANCE ______________________ MEMBER # ______________________ GROUP # __________

YOU MAY COMMUNICATE WITH THE FOLLOWING INDIVIDUALS REGARDING MY CONDITION OR TREATMENT

____

____

PLEASE TURN OVER AND COMPLETE BACK

SIGNATURE ON FILE

I hereby authorize payment of Medicare, Medicaid and/or other health insurance benefits to ANNISTON EYE CLINIC for professional services rendered. I authorize the release of any necessary medical information, including copies of medical records, for determination of payment of benefits. I understand that ANNISTON EYE CLINIC accepts assignment for Medicare, Blue Cross, Medicaid and other HMOs and PPOs with which they are affiliated, and that I am responsible for any deductions, co-pays and/or fees for non-covered services such as office visits without required referral, refraction fees, non-medically related office visits, deluxe frames not covered by any insurance/vision plan (when applicable) and contact lens fitting fees.

FINANCIAL POLICY

If you have insurance with which we are unfamiliar or that we know from experience will not pay benefits directly to us, the undersigned will be responsible for fees for services rendered and we will gladly file your insurance for reimbursement to you. However, it is the undersigned's responsibility to handle any and all problems that arise with your insurance company. Again, we are happy to re-file any claims per the undersigned's request after the insurance company has been contacted to verify that re-filing is necessary.

You agree, in order for us to service your account or to collect monies you may owe, ANNISTON EYE CLINIC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

ANNISTON EYE CLINIC cannot guarantee anything about the undersigned's insurance as the contract is between the undersigned and their insurance company, not with this office. We will assist in any way possible, but it is the responsibility of the undersigned to know their insurance. The undersigned is responsible for obtaining referrals when necessary.

If a balance remains on the account after 30 (thirty) days; a 1.5% late fee will be added monthly to the unpaid balance. There is a $40 returned check fee. I, the undersigned accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all costs of collections, (33.35%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right of exemption under the laws of the Constitution of the State of Alabama, and any other state.

I HAVE READ AND UNDERSTAND THE ABOVE STATED FINANCIAL POLICY AND AGREE TO ALL CONDITIONS. I ALSO AGREE THAT IN THE UNUSUAL EVENT THAT MY ACCOUNT BECOMES DELINQUENT, I WILL PAY ANY COLLECTION FEES REQUIRED TO SETTLE MY ACCOUNT.

______________________________ DATE ______________________

RESPONSIBLE PARTY'S SIGNATURE