Desert EyeCare Center
Family is our focus

PATIENT UPDATE FORM

CONTACT INFORMATION

Patient Name: _____
First MI Last

Birth Date: _____ Today's Date: _____

Please **update any changes** to your phone number, address, or email on the lines below:

Phone: _____

Address: _____

Email: _____

HIPAA NOTICE AND ACKNOWLEDGMENT

I have been presented a copy of the Privacy Practices and have been offered a copy for my records.

Printed Name: _____

Signature: _____

Desert EyeCare Center may discuss my medical information and insurance information with:

Name: _____ Relationship:_____

CONSENT TO TREAT

I hereby give my consent to Desert EyeCare Center to provide eye care services to myself and/or family.

Signature: _____

I request that payment of authorized insurance/Medicare benefits be made on my behalf to Desert EyeCare Center(DECC)/ Dr. Kelley Lawrence. This is to include medical services rendered by myself and/or dependents. I assume responsibility for any deductible, co-payment, or other balance not covered by my insurance carrier. Authorization obtained at the time of service does not guarantee payment. As a service to the patient, DECC will submit claims to your insurance carrier. However DECC cannot guarantee that these claims will be honored. All denied claims will be billed to the patient. I recognize that it is my responsibility to know and understand my insurance coverage, or lack thereof. I understand that professional fees are due upon completion of the exam, and that these services are non-refundable. I understand that all glasses and contact lens orders are non-refundable. I authorize the doctor to release all information necessary to secure payment of benefits.

Signature _____Date: _____