ANDOVER OPTOMETRY ON CENTRAL
15 Central Street, Andover, MA 01810
(978) 475-5252 www.andoveroptometry.com

PATIENT INFORMATION			
Name:		Nickname:	Sex: ☐ Male ☐ Female
Address:		Date of Birth:	
City / State / Zip:		SSN:	
Home phone:	Work phone:	Cell phone:	
Email:		Preferred Contact: ☐ Home ☐ Work ☐ Cell ☐ Email ☐ Text	
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify	Race: ☐ American Indian / Alaskan Native ☐ Asian ☐ Black / African American ☐ Native Hawaiian / Pacific Islander ☐ White ☐ Decline to Specify		
Employer:	Employer Address:		
Occupation:			

INSURANCE INFORMATION		
Subscriber / Guarantor:	Sex: ☐ Male ☐ Female	SSN:
Address:		Date of Birth:
City / State / Zip:		Relationship to Patient:
Home phone:	Work phone:	Cell phone:

VISION INSURANCE		
Insurance:	Policy ID No:	Policy group:

PRIMARY MEDICAL INSURANCE	SECONDARY MEDICAL INSURANCE
Insurance:	Insurance:
Policy ID No:	Policy ID No:
Policy group:	Policy group:

VISION AND MEDICAL INSURANCE POLICIES

As part of the services provided by Andover Optometry on Central, we are happy to assist you in determining the benefits of your individual policy and in collecting the reimbursement of insurance benefits for vision and medical services provided. The following are our policies regarding insurance and payment for services and materials our practice provides to you:

1. The legal obligations of your insurance provider are between yourself and your provider, not between this practice and your provider.
2. When your insurance provider(s) has settled your plan's covered items, you will be notified by a monthly statement if there were any unpaid balances. Unpaid balances can include non-covered items or services, co-pays, deductibles, lapses, ineligibility or termination of coverages. Unpaid balances are the sole responsibility of the patient.
3. Any amounts that are pre-determined to be the patient's responsibility, including co-pays, overages, and non-covered items or services will be due at the time of service.

Patient name:

VISION AND MEDICAL INSURANCE AUTHORIZATIONS

I authorize the use of this form and the release of my personal and medical information to all my insurance companies for the purpose of obtaining payment for covered services.
I authorize Andover Optometry on Central to act as my agent in obtaining payment from my insurance companies.
I authorize payment of my insurance benefits for any services provided to be made directly to Andover Optometry on Central.

_____ _____ _____

Name of Patient or Guardian | Signature of Patient or Guardian | Date

OFFICE POLICIES AND AUTHORIZATIONS

POLICY FOR COMMUNICATING BY EMAIL OR TEXT:

As part of our patient communication system, we can send you emails or texts for any of the following purposes:

- To inform you that you are due to return for your eye examination
- To remind you of upcoming appointments or notify you of missed appointments
- To notify you that your glasses or contact lenses are ready to be picked up
- To invite you to provide feedback via periodic surveys on a voluntary basis

We will only contact you via these methods for the above purposes. We will only send the above messages through our certified Electronic Medical Record system, MyVisionExpress, and not with personal devices. We will adhere to HIPAA guidelines and will not put any protected health information (PHI) into these messages.

CONSENT TO RECEIVE EMAILS AND TEXTS FROM DR. RONALD WATANABE AND ASSOCIATES:

☐ I agree to receive emails from Andover Optometry on Central.
☐ I agree to receive text messages from Andover Optometry on Central. I understand that I will be solely responsible for any charges incurred from my mobile carrier for the receipt or sending of these messages.
☐ I do not wish to receive emails or text messages from Andover Optometry on Central.

SCREENING RETINAL PHOTO AUTHORIZATION:

Our doctors recommend a screening digital retinal photo be taken during your routine eye examination. Screening photos are not covered by vision or medical insurance. The purposes of these photos are to:
1. document your retinal health to establish a baseline to which future retinal exams can be compared to detect changes over time.
2. help detect subtle retinal and optic nerve abnormalities that may affect vision and ocular health.
I understand that this retinal photo does not take the place of a retinal exam by the doctor.
I authorize Andover Optometry on Central to take screening photos of my retinas.
☐ I agree to pay the $35 fee for these screening retinal photos.
☐ I decline these screening retinal photos.

CONSENT TO USE MY IMAGES OR LIKENESSES FOR IN-OFFICE PRESENTATIONS:

☐ I authorize Andover Optometry on Central to use images and videos of my eye or my likeness for the purpose of in-office educational or marketing presentations. I release ownership of these images and videos to Andover Optometry on Central. I will not be compensated in any way for the use of these images or videos.
☐ I do not wish to have images of me or my eye displayed for the above purposes.

CONSENT FOR TREATMENT:

I hereby authorize Andover Optometry on Central to administer diagnostic and medical procedures as may be necessary for proper eye care.

_____ _____ _____

Name of Patient or Guardian | Signature of Patient or Guardian | Date