Family Eye Care

Acknowledgment of Receipt of Notice of Privacy Practices

By my signature below, I acknowledge that I have received Family Eye Care's Notice of Privacy Practices.

Patient Name: _____Patient Date of Birth _____

Any physician, staff, employee or representative of Family Eye Care has my permission to **discuss** my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment.

_____	_____	_____
Name	Relationship	Phone Number(s)
_____	_____	_____
Name	Relationship	Phone Number(s)
_____	_____	_____
Name	Relationship	Phone Number(s)

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke in writing to Family Eye Care or completing a new form at any time. This authorization will remain in effect until I change or Revoke it. I understand that if information is shared with the above individuals it may be subject to re-disclosure by the individuals.

Patient or Guardian's Signature _____ Date: _____

We use SOLUTIONREACH network to communicate electronically with our patients via email and texts. This network can notify you of your future appointments and also alerts you electronically when your glasses and/or contacts order is ready for pick-up.

Can we communicate with you via email? ____YES ____NO

Can we communicate with you via texts? ____YES ____NO _____No, I do not text.

Please update information below:

Address_____ City_____ Zip code_____

Cell phone _____

Email Address_____

Insurance Information

Medical Insurance: _____ Member I.D. #_____

Vision Insurance: _____ Member I.D. # _____

FAMILY eye care

Dr. William D. Gordon • Dr. Anthony Lamar

LATE / NO SHOW POLICY

Late Policy

If a patient is going to be late we ask you call to let us know you are on your way. However, if you are going to be more than 15 minutes late, your appointment will be rescheduled.

No Show Policy

Patients wanting to cancel an appointment are asked to call the office 24 hours in advance. Patients who "no show" three times with no previous notification will not be allowed to schedule appointments with Family Eye Care.

Informed Consent / Agreement

I have been informed and understand Family Eye Care's late & no show policy.

_____ YES **_____ NO**

_____ _____

Patient or Guardian's Signature **Date**