**William F. Pittenger, Jr., OD**

*Doctor of Optometry:* University of Alabama School of Optometry, 1983

*Past President:* North Alabama Optometric Society

*Member:* American Optometric Association, Alabama Optometric Association, North Alabama Optometric Society

*Comprehensive care for clear, healthy vision:*

- Medical optometry
- State-of-the-art eye exams
- Certified technicians
- Certified opticians
- Full-service dispensary
- Over 1,000 frames
- The latest lens technologies
- Complete contact lens selection

*Diagnosis of many conditions, including:*

- Glaucoma
- Diabetic retinopathy
- Cataracts
- Macular degeneration
- Retinal tears and detachments

*Advanced solutions for:*

- Irritated, tearing or dry eye
- Eye allergies
- Eye infections
- Foreign bodies

PLEASE PRINT

NAME:

Mr. Mrs. Miss Ms. Dr.

______________________________________________

(First) (Middle) (Last)

(As listed on insurance)

STREET: ______________________________________________

APT NUMBER: ______________________________________________

CITY/STATE/ZIP: ______________________________________________

HOME TELEPHONE: (_____) _______ - __________

WORK TELEPHONE: (_____) _______ - __________, EXT: _______

CELLULAR PHONE: (_____) _______ - __________

E-MAIL ADDRESS: ______________________________________________

DOB: __________ / __________ / __________ AGE: _______

MONTH DAY YEAR

Marital Status: Single Married Divorced Widowed Separated

SS#______/______/______

---

OCCUPATION: ______________________________________________

EMPLOYER: ______________________________________________

If student, full-time part-time

---

SPOUSE / PARENT / OTHER ______________________________________________

REFERRED BY: ______________________________________________

---

NAME OF PRIMARY CARE DOCTOR: ______________________________________________

TELEPHONE NUMBER: (_____) _______ - __________

ADDRESS OF PRIMARY CARE DOCTOR: ______________________________________________

______________________________________________

---

EMERGENCY CONTACT: ______________________________________________

TELEPHONE NUMBER: (_____) _______ - __________

RELATIONSHIP OF EMERGENCY CONTACT: ______________________________________________

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**Insurance Information: Check Medical, Vision Or Both. Please List Primary Insurance First.**

☐MEDICAL/☐VISION: ____________________

INSURED/SUBSCRIBER NAME: ____________________

INSURED/SUBSCRIBER ADDRESS (IF DIFFERENT FROM PATIENT):

____________________

____________________

INSURED/SUBSCRIBER DATE OF BIRTH: ________ / ________ / ________ ☐M ☐F
MONTH DAY YEAR

RELATIONSHIP TO PATIENT: ____________________

GROUP NUMBER: ____________________ COPAY: ____________________

CONTRACT/POLICY NUMBER: ____________________ STARTING DATE: ____________________

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MONTH DAY YEAR

RELATIONSHIP TO PATIENT: ____________________

GROUP NUMBER: ____________________ COPAY: ____________________

CONTRACT/POLICY NUMBER: ____________________ STARTING DATE: ____________________

**256.536.4489**

806 Regal Drive • Huntsville, AL 35801 | Fax: 256.536.4399 | www.2020EyeCareHSV.com

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**1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to William F. Pittenger, Jr., O.D., P.C., William F. Pittenger, Jr., O.D., (d.b.a. 20/20 Eye Care Centers), for services furnished me by 20/20 Eye Care Centers. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payments be made and authorize release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500-2007 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. 20/20 Eye Care Centers accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.**

**2. SECONDARY INSURANCE: I understand that if a secondary policy or other health insurance is indicated in Item 9 of the HCFA 1500-2007 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to 20/20 Eye Care Centers, if possible, or otherwise to me.**

**3. RELEASE OF INFORMATION: 20/20 Eye Care Centers may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to 20/20 Eye Care Centers for reimbursement for services rendered, and (2) any health care provider for continued patient care. 20/20 Eye Care Centers may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statue or regulation. A copy of this authorization may be used in place of the original.**

**4. OTHER INSURANCE: I understand that 20/20 Eye Care Centers maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. 20/20 Eye Care Centers has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by 20/20 Eye Care Centers if I belong to a plan that does not appear on the above mentioned list.**

**5. NON-COVERED SERVICES: I understand that 20/20 Eye Care Centers contracts with health care service plans (i.e., HMO's, PPO's) relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the health summary the health care service plan furnishes to the patient, and treatment or tests not authorized by the health care services plan. The undersigned agrees to cooperate with 20/20 Eye Care Centers.**

**6. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by 20/20 Eye Care Centers, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to 20/20 Eye Care Centers for payment. If an account is sent to a collection agency or an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other part liable to the patient, is hereby assigned to 20/20 Eye Care Centers. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to 20/20 Eye Care Centers. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.**

**7. CONSENT TO TREATMENT: I authorize the physicians of 20/20 Eye Care Centers, their technicians and other health care providers under their direction to provide diagnostic evaluation and treatment. I agree to pupillary dilation for the purpose of examination, which could affect driving. I understand that no guarantee has or will be made to me regarding any possible result or cure based on my examination and/or treatment.**


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**Consent for Purposes of Treatment, Payment & Healthcare Operations**
**In this document, "I" and "my" refer to the patient,**
**and "Optometrist" refers to William F. Pittenger, Jr., O.D., P.C.**

**I consent to the use or disclosure of my protected health information by Optometrist for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Optometrist. I understand that analysis, diagnosis or treatment of me by Optometrist may be conditioned upon my consent as evidenced by my signature below.**

**I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Optometrist is not required to agree to the restrictions that I may request. However, if Optometrist agrees to a restriction that I request, the restriction is binding on Optometrist.**

**I have the right to revoke this consent, in writing, at any time, except to the extent that Optometrist has taken action in reliance on this Consent.**

**My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.**

**I have been provided with a copy of the Notice of Privacy Practices of Optometrist and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Optometrist. The Notice of Privacy Practices for Optometrist is also posted in the waiting room at 806 Regal Drive, Huntsville, AL 35801. This Notice of Privacy Practices also describes my rights and duties of the Optometrist with respect to my protected health information.**

**Optometrist reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Optometrist and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.**

**The following persons are allowed to access to my protected health information (include all physicians and family members):**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

________________________________________ ________________________________________

**Signature of Patient or Personal Representative** **Printed Name of Patient**

________________________________________

**Description of Personal Representative**

________________________________________ ________________________________________

**Signature of Patient or Responsible Party** **Date**

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