DOTHAN OPHTHALMOLOGY, P.C.

Patient Information

Patient Name_____ **Sex**_____
Last First Middle

Mailing Address_____
Street City State Zip Code

Email Address: _____

Home Phone_____ **Cell Phone**_____ **Work Phone**_____

Preferred Method of Communication: Text_____ **Phone**_____

Date of Birth _____ **Social Sec.#**_____

Marital Status S M W D **Spouse's Name**_____

Race: ____ American Indian/ Alaska Native ____ Asian ____ Black/ African American

____ Nat. Hawaiian / Pacific Islander ____ White

Ethnicity: _____ Hispanic or Latino _____ Not Hispanic or Latino

Primary Language _____

Employer_____ **Phone**_____

Preferred Pharmacy_____ **Phone**_____

Insured's Name _____

Insured's Date of Birth_____ **Social Sec. #**_____

Address_____
Street City State Zip Code

Relationship to Patient_____ **Phone Number**_____

Employer_____ **Phone Number**_____

I consent to treatment necessary or desirable for myself or my dependent, including medications required in the process of treatment or diagnosis by Dr. Joseph H. Sugg, Jr., or his staff. I accept full responsibility for the payment of these services. I agree to pay for them at the time the service is rendered. I understand that the fees for professional care may not be covered in full by my insurance. I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and /or court costs, if such be necessary

I authorize payment of medical benefits on my behalf to Dothan Ophthalmology, Dr. Joseph H. Sugg, Jr., and I authorize the release of my medical information to my insurance companies or public agencies (such as Medicare, Medicaid, BCBS, etc.) as necessary.

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER

You agree, in order for us to service your account or to collect monies you owe, Dothan ophthalmology, 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 pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable. I/we have read this disclosure and agree that Dothan Ophthalmology, its employees and/or agents may contact me/us as described above.

Initial_____

After 90 days balance will be turned over to a collection agency unless payment arrangements have been made.

Initial_____

Print Name _____

_____

Responsible Party Signature

Date_____