Fee Consent Form

I______________________________________hereby consent to:

• Providing my insurance company information

• Accepting payment receipts and optical prescriptions via email

• Providing my personal health information to ensure the time I spend in the office is efficient and focused on my medical care

• Being automatically charged a fee of $50.00 if I do not attend my appointment or cancel with less than 24 hours notice.

NOTICE OF COLLECTION OF PERSONAL INFORMATION AND CONSENT TO COLLECT

"We" and "our" mean the following optometric practice: STC Optometry

READ CAREFULLY BEFORE SIGNING: By signing this form, you consent to our collection of the information above.

We collect, use, and share your personal information for the following purposes: your ongoing eye care; to provide services to you; to understand your eligibility for benefits and/or services; to arrange payment for services; and as required by law.

The collection of this information is authorized by the Health Insurance Act, Optometry Act, Regulated Health Professions Act and Health Protection and Promotion Act.

We will take all reasonable steps to ensure that your personal information is treated confidentially and is only used for the purposes it was collected. We will take all reasonable steps to prevent unauthorized access, use or disclosure of your personal information.

You may obtain access to your personal information stored by us in accordance with the Personal Health Information Protection Act by making a written request to: info@stcoptometry.com.

If you would like to make a comment or complaint regarding the collection, use, disclosure or handling of your personal information you may contact: Dr. Mandeep Bains.

You also have the right to complain to the Information Privacy Commissioner / Ontario, 1400-2 Bloor Street East, Toronto, ON M4W 1A8 (800-387-0073)

I AM AWARE THAT THE FEE FOR THIS APPOINTMENT IS $_______

I,_______________________________________have read the information on this form and DO consent to the above.

Signed:____Date:____

1. Patient Information

Last Name:	First Name:	Middle Initial:
Date of Birth:	Address:	

Gender:	City:	Province:	Postal Code:	Country:

Home Phone:	Cell Phone:	Email Address:

Preferred Method of Contact: ☐ Home Number ☐ Cell Phone ☐ Email Address

Family Doctor Name:	Family Doctor Phone Number:

Emergency Contact Name:	Relationship with Patient:	Emergency Contact Number:

2. Health Card and Vision Insurance

Please provide staff your health card and vision insurance information to determine eligibility.

3. Medical History

Please check here If NO MEDICATIONS: ☐

Medications: List all medications and eye drops			**Allergies:**
Dose:	Name:	Purpose:	

Please check here if all of the following is NO ☐

Self	**Eye History**	Family
	Cataracts	
	Glaucoma	
	Retinal Detachment	
	Macular Degeneration	
	Lazy Eye / Eye Turn	
	Trauma	
	Eye Surgery:	
	Other:	

Please check here if all of the following is NO ☐

Self	**Medical History**	Family
	Diabetes	
	High Blood Pressure	
	Elevated Cholesterol	
	Thyroid Disorder	
	Asthma/ COPD	
	Sleep Apnea	
	Stroke	
	Other:	