PATIENT INFORMATION

NAME _____ SOC. SEC. NO. _____

ADDRESS _____

TELEPHONE _____

BIRTH DATE _____

REFERRED BY _____

EMPLOYED BY _____

ARE YOU COVERED BY VISION INSURANCE? _____

PARENT OR GUARDIAN (IF MINOR) _____

WHEN WERE YOUR EYES LAST EXAMINED _____

WHY DO YOU FEEL THE NEED FOR A VISION EXAMINATION? _____

_____

Acknowledgement of Receipt of Privacy Policies

I do acknowledge that I received a copy of the Notice of Privacy Practices for this Office.

SIGNED: _____ Date: _____

Insurance Authorization & Payment acknowledgement

I request that payment of authorized Insurance benefits for any services furnished me, be made on my behalf to EYE CARE CLINIC.

I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand that I am responsible for charges not paid by the insurance plan.

Should the account be referred for collection the undersigned shall pay reasonable attorney fees and collection expenses. All delinquent accounts bear interest at the legal rate. In the event of court action venue and jurisdiction shall be Lewis County in the State of Washington.

SIGNED: _____ Date: _____