

# Welcome to our Office

<p style="text-align: center;"><b>Patient Information:</b></p> <p>This information is confidential and only used for office purposes such as notices, recalls, confirming appointments and passwords set up to ordering contact lenses online. This information <i>will never be shared</i></p>	<p style="text-align: center;"><b>Insurance:</b></p> <p><b>We will file your insurance benefits for you.</b> <b>We are a medical facility. Medical Insurance covers our services. Vision Insurance cover optical benefits.</b></p>
<p><b>Circle:</b> Dr Mr Mrs Ms Miss Jr Sr I II III</p> <p>Name: _____                     First                    MI                    Last</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Please call me: _____</p> <p>Date of Birth: ____/____/____ Age: _____ gender M or F</p> <p>E-Mail: _____@_____</p> <p>Home Phone: (____)____-____</p> <p>Work Phone: (____)____-____</p> <p>Cell Phone: (____)____-____</p> <p>Employer: _____</p> <p>Occupation: _____</p>	<p style="text-align: center;"><b>Please read as the following information:</b></p> <ul style="list-style-type: none"> <li>If you do not tell us you have Medical Coverage or Vision Plan before service or goods are rendered, we will assume no coverage exists.</li> <li>Our Office with <b>NO EXCEPTIONS</b>, will not back file claims, post authorize claims or refund professional fees.</li> <li>If you discover you have Medical or Vision coverage after professional services or products are rendered, it is your responsibility to file your own claim for reimbursement. We will help you file your claim.</li> </ul>
<p style="text-align: center;"><b>Whom may we thank for Referring You?</b></p>	<p style="text-align: center;"><b>Medical / Health Insurance Information:</b></p> <p>Insurance: _____</p> <p>Employer: _____</p> <p>Primary Insured's Name _____</p> <p>Relationship: Circle one: Self Spouse Child Other</p> <p>Ins ID#: _____ Group# _____</p> <p>Ins SS# _____ - _____ - _____ DOB ____/____/____</p> <p>Phone Number on Card (____)____-_____</p>
<p style="text-align: center;"><b>Acknowledgement of Privacy Policy</b></p> <p>____ I have read or been presented with the HIPAA Privacy Policy manual and wish to continue care.</p> <p>____ I have not read the HIPAA Privacy Policy</p>	<p style="text-align: center;"><b>Optical Benefits Information:</b></p> <p>Insurance: _____</p> <p>Employer: _____</p> <p>Primary Insured's Name _____</p> <p>Relationship to Insured: Circle one: Self Spouse Child Other</p> <p>Ins ID#: _____ Group# _____</p> <p>Ins SS# _____ - _____ - _____ DOB ____/____/____</p> <p>Phone Number on Card (____)____-_____</p>
	<p style="text-align: center;"><b>Person responsible for payment Information:</b></p> <p><b>Name:</b> _____</p> <p>Phone number: _____</p> <p>Relationship: Circle one: Self Spouse Child Other _____</p>
	<p style="text-align: center;"><b>Please Read and Sign:</b></p> <p style="text-align: center;"><i>I have read and understand the terms and policies of Eye and Vision and allow Eye and Vision Management to file for insurance payments or collect payment.</i></p> <p style="text-align: center;"><i>I certify that the information supplied on this statement is accurate to the best of my knowledge.</i></p> <p><b>Signed:</b> _____ <b>Date:</b> _____</p>