Welcome to Primary EyeCare

Patient Information:

Date:_____

Last Name_____ First Name_____DOB:_____Gender:_____

Address:_____

City:_____ State:_____ Zip:_____

Day Phone:_____Cell Phone:_____Email:_____

How did you hear about us?: ☐ Current Patient ☐ Web/Facebook ☐ Mailer ☐ Referral_____from who?

Name of Insured/Policyholder_____ **DOB**:_____

Name of Insurance Carrier:_____

ID #: _____**Group #:**_____

Insurance Card Copied: ☐ **Yes** ☐ **No** ☐ **No Card**

Tricare/Triwest/VA members/Need full social security # _____

Are you a member of VSP (Vision Service Plan) ☐ **Yes** ☐ **No** **Last 4 #'s of policyholder's social security #** _____

Authorization and Release:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and /or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor, insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. In order for my eyecare provider/associates to service my account, or to collect any amounts I may owe, I agree that I may be contacted at any number or address I have provided above or during a previous encounter. I furthermore agree to pay any collection expenses incurred to collect any amount I may owe due to non-payment.

I authorized the release of any information including the diagnosis and the records of any treatment or examinations rendered to me or my minor child to:_____

_____ _____

Signature of Patient or Parent (if mInor) Date

HIPAA Privacy Practice Acknowledgment

I have received or was offered and declined a notice of privacy practices.

Signature:_____ Date:_____