Kennedy
Vision Health Center

Date: _____/_____/_____

First Name: _____ MI: _____ Last Name: _____

Address: _____

DOB: _____/_____/_____ Age: _____ Social Security Number: _____

Cell Phone Number: _____ - _____-_____ Home Phone Number: _____ - _____-_____

Work Phone Number: _____ - _____-_____Email Address: _____

Preferred Contact (please list at least one phone contact):

☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Email ☐ Text ☐ Other: _____

May we contact you via email? ☐ Yes ☐ No May we contact you via text? ☐ Yes ☐ No

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ Indian ☐ Other _____

Preferred Language: ☐ English ☐ Other _____

How did you hear about our office?

☐ Phone Book ☐ Online Yellow Pages ☐ Website ☐ Newspaper Ad ☐ Drive By ☐ Insurance Company

☐ Direct Mailing ☐ Family or Friend (Name): _____ (We would like to thank them)

☐ Other:

Name of Primary Medical Insurance: _____

Name of Insurance Policy Holder? ☐ Self ☐ Other: _____ DOB: ____/_____/_____

Do you have Vision Insurance (VSP, EyeMed)? ☐ Yes ☐ No

I, undersigned have insurance coverage with the above named insurance carrier or carriers and assign directly to Kennedy Vision Health Center, LLC all medical and/or surgical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

As a courtesy we will submit your claim form for you. Payment made by your insurance company will be immediately credited to your account. The remaining balance is due at the time of your next statement. We will prepare reports, other paperwork and follow through as needed for a nominal fee to the party requesting additional information. Most insurance companies process claims within 45 days. If your claim has not been processed by then, payment from you is expected for the total amount of the claim submitted. I acknowledge that I have been given access to / received a copy of Kennedy Vision Health Center's HIPPA notice of privacy practices. **Form must be signed to authorize claim filing.**

Authorized Signature: _____Date: _____/_____/_____

Authorized Signature: _____Date: _____/_____/_____

Authorized Signature: _____Date: _____/_____/_____