PATIENT INFORMATION

Thank you for choosing our office for your eyecare needs. We strive to provide the best care possible and appreciate the confidence you have placed in us. Please help us to serve you better by completing these forms.

Name: Mr. Mrs. Ms. Miss Dr. ____

Nickname: ___________________ Date of Birth: _____________ Age: _______ SSN Last 4: ___________

Address: ____

City: ____ State: ________ Zip: ____________

Home (______)______________Cell (_____)________________ Work (_____)______________X_______

Employer: _______________________ For Minor, Parent/Legal Guardian's Name:_____________________

How did you hear about our office? family/friend location insurance internet professional referral

Whom may we thank for referring you to us? ____

If circled internet, what search engine? ____

How would you prefer to be contacted? (please circle) **PHONE** **TEXT** **EMAIL** **MAIL**

Email: □□□□□□□□□□□□□□□□□□□□□□□□□□□□□□

Vision Insurance: __________________________________

Name of Primary Insured (if other than patient): ____________________________Relation: ___________
Date of Birth: ____________
Social Security # or ID: ______________________Employer: ______________________________

Medical Insurance: Medicare ___ Aetna ___ Premera ____ Regence ____ Blue Cross Blue Shield _____
United Health ____ Kaiser ____ Other ____________________________________

Insurance Authorization, Release and HIPAA Notification

I hereby authorize my insurance benefits to be paid directly to Envision Optometry. I also authorize Envision Optometry to release any information required for the claim. **Initial** _______

I understand that I am responsible for the cost of services provided. Any insurance information provided by Envision Optometry is an estimate only, and is subject to change. I understand that Envision Optometry does not bill secondary insurances, but can provide a detailed receipt that I can submit for reimbursement. In the event a collection action should be required, I agree to pay the costs of collection including the collection fees, court costs and reasonable attorney fees. **Initial** _______

I am aware that prescription lenses are specially fabricated for each individual patient and, due to their custom nature, there are NO REFUNDS on lenses. Orders must be cancelled within 24 hours of being placed. **Initial** _______

I authorize the release of information from my medical records if requested by Dr. John C. Brown or Dr. Angela Lin in relationship to my health care. **Initial** _______

I have been given an opportunity to read and/or receive a copy of the Notice of Privacy Practice Acknowledgement and Release of Information Authorization. **Initial** _______

Signature ____ Date ____________________________