

VISION SOURCE

Welcome Back To Our Office

HAVE THERE BEEN ANY CHANGES TO YOUR HEALTH OR MEDICATIONS PRESCRIBED SINCE WE LAST SAW YOU? IF SO, PLEASE LIST:

Mr. Miss Mrs. Ms.

Male Female

First Name MI Last Name Preferred Name

Street Address City State Zip

Social Security Number Date of Birth Home Phone - Include Area Code Day Phone

Email Address Guardian Person Responsible for Account

Emergency Contact Emergency Phone

How were you referred to our office?

Who were you referred by?

Phone Book School Advertisement Patient

Insurance Listing Drive by Other Doctor

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company City State Zip

M F

Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured

Self Spouse Child Other

Patient Status

Single Married Other

Full Time Student Part Time Student Employed

Please Read:

HIPAA COMPLIANCE:

Our notice of Privacy Practices is posted at the reception area for your convenience. Please inform the front office staff if you would like a copy for your records, otherwise it is also available on our website. Thank you. By signing below, I acknowledge that I received notice of Vision Source's Notice of Privacy Practices. Vision Source does maintain patient records for a minimum of five years.

INSURANCE BILLING:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge of \$25.00 on all returned checks.

Payment for my insurance is to be paid directly to Vision Source. I understand that my primary insurance will be billed by Vision Source as a courtesy and that I am primarily responsible for billing any secondary insurance. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature

Date