Welcome To Our Office

Name: ____ Date: ____/____/____

Home Address: _________________________________ Home Phone : ________

City : ________________________ State : ________________ Zip: __________

Male ___ Female ____ Birth Date : ____________ Social Sec # ______________

Name of Parent / Guardian (if Patient is a Minor) : __________________________

Employed By : ______________________________ Work Phone : ____________

Emergency Contact : ___________________________ Phone : _______________

WHOM MAY WE THANK FOR REFERRING YOU TO US ? : ________________

FINANCIAL INFORMATION

To keep our office fees to a minimum, each patient is expected to make full payment for services on the date of each visit. When eyeglasses, contact lenses, or low visual aids are ordered, a minimum deposit of ½ of the materials fees is required. The balance is due when the materials are dispensed. You are financially responsible for your business conducted at this office. We will assist you to help assure appropriate reimbursement from your insurance company. This office does not charge for completing insurance forms, but does charge $20 for each returned check. A 1.5 % monthly service fee will be charged for delinquent accounts.

PRIVACY AUTHORIZATION

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information. You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place restrictions on the use or disclosure of your health information, please let us know in writing. I have received and read the privacy policy of Memphis Family Vision Practice.

Signature: ___________________________________ Date : _____________

I authorize the release of any medical information to another health care provider if it is necessary to refer me for diagnosis or treatment. I also authorize the release of any medical information necessary to process claims for services and / or materials rendered by The Memphis Family Vision Practice doctors or staff. I request payment of insurance benefits to the party who accepts assignment on the claim form. I understand that I am responsible for any services and / or materials received by me from this office. I agree to pay any collection or attorney fees associated with the collection of my outstanding debt. I agree to the terms of the consent policy by signing below.

Signature: ___________________________________ Date : _____________