PATIENT NAME (Last, First) _____ Birthdate _____ Date _____

Parent/Guardian _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Updated _____ Date _____

Phone #s Home (_____) _____ Work (_____) _____ Cell (_____) _____

Optical Insurance Co. _____ Email: _____

Patient's relationship to subscriber _____

Subscriber name _____

Subscriber DOB _____

Employer _____

Group name or # _____

Contract / UID # _____

Primary Social _____

Secondary Optical Insurance _____

Patient's relationship to subscriber _____

Subscriber name _____

Subscriber DOB _____

Employer _____

Group name or # _____

Contract / UID # _____

Second Social _____

Medical Insurance Co. _____

Patient's relationship to subscriber _____

Subscriber name _____

Subscriber DOB _____

Group name or # _____

Contract / IUD # _____

Secondary Medical Insurance _____

Patient's relationship to subscriber _____

Subscriber name _____

Subscriber DOB _____

Group name or # _____

Contract / IUD # _____

Memo _____

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

– Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

– Obtain payment from third-party payers.

– Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by The Visionary of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that The Visionary has the right to change its Notice of Privacy Practices from time to time and that I may contact The Visionary at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that The Visionary restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that The Visionary is not required to agree to my requested restrictions, but if The Visionary does not agree then they are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that The Visionary has taken action relying on this consent.

Patient Name _____

Patient/Parent Signature _____

Relationship to Patient _____

Date _____

BILLING POLICY

I understand that The Visionary will bill my insurance company as a courtesy if applicable.

I authorize payment of benefits directly to The Visionary. **Should payment come to me instead of The Visionary, I agree to pay the balance due, in full, immediately.**

I agree that I am ultimately responsible for any amount owed by myself or my insurance company, that I will pay the balance within 30 days of notification of balance due, and that any amount due to me, the patient, will be refunded.

I understand that amounts due not paid within 30 days of notice may be placed for collection and/or with the 24th District Court and that I will be responsible for all collection costs and fees.

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____