VISION ONE

Welcome to Our Office

Today's date: _____

☐ New patient ☐ Former patient ☐ Minor

Name: (Last) _____ (M) _____ (First) _____

Date of Birth: _____ Phone: (H) _____ (Mobile) _____

Address: _____ City: _____ Zip: _____

E-mail address: _____

If age is less than 18 years old, name of Guardian: _____

Names of other family members seen at this office: _____

Marital status: Married YES / NO

YOU MUST COMPLETE THE INSURANCE INFORMATION SECTION

Name of MEDICAL Insurance:	**Name of VISION Insurance:**
Member ID #:_____	**Social security #** _____
Group #:_____	**Name of primary care holder:** _____
Employer:_____ ☐ **Fulltime** ☐ **Part-time** ☐☐ **Retired**	**Date of birth of primary care holder:** _____/_____/_____

Is MEDICARE your primary insurance: : ☐ **YES** ☐ **NO**
Is MEDICARE insurance under HMO? ☐ **YES** ☐ **NO**

Do you have a supplementary insurance? ☐ **YES** ☐ **NO**
Name of your supplementary insurance :_____
Member ID # :_____
Group#:_____

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Vision One Eyecare/ LTW Vision Empire, P.A. on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorized my doctor to act as my agent, as above.

All insurance must be presented at the time of service. **Professional fee are non-refundable and non-negotiable**
We do not bill for service. Payment must be collected at the time service rendered.
For insurance patients, please be aware that you are fully responsible for services not covered by your insurance plan.
I also acknowledged that I have the opportunities to review and receive a copy of the notice of privacy practices.

X_____ _____

Lifetime Patient Signature on File Date