Kennedy
Vision Health Center

First Name: _____ MI: _____ Last Name: _____ □ Male □ Female

Address: _____City:_____State:_____Zip:_____

DOB: _____/_____/_____ Age: _____ Social Security # (or last 4 #s): _____

Cell Phone Number: _____ - _____-_____ Home Phone Number: _____ - _____-_____

Work Phone Number: _____ - _____-_____ Email Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Preferred Contact (Please select one): □ Cell Phone □ Home Phone □ Work Phone □ Email □ Text

May we contact you via email? □ Yes □ No **May we contact you via text message?** □ Yes □ No

Race: □ Caucasian □ African American □ Asian □ Hispanic □ Indian □ Other _____

Preferred Language: □ English □ Other _____

How did you hear about our office?

□ Existing Patient
□ Insurance Company □ Website □ Newspaper Ad □ Drive By □ BNI □ Direct Mailing
□ Family or Friend (Name): _____ (We would like to thank them)
□ Other: _____

Name of Primary Medical Insurance: _____

Name of Insurance Policy Holder? □ Self □ Other: _____ DOB: ____/_____/_____

Do you have separate Vision Insurance (VSP, EyeMed)? □ Yes □ No

I, undersigned have insurance coverage with the above named insurance carrier or carriers and assign directly to Kennedy Vision Health Center, LLC all medical and/or surgical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

VSP policy holders: I understand that my medical records are confidential. I understand that by signing this consent form I am allowing my medical information to be released upon VSP's request, for the purpose of Health Care Operations. I also understand that I may revoke this consent by written request, at any time, with this doctor.

As a courtesy we will submit your claim form for you. Payment made by your insurance company will be immediately credited to your account. The remaining balance is due at the time of your next statement. We will prepare reports, other paperwork and follow through as needed for a nominal fee to the party requesting additional information. Most insurance companies process claims within 45 days. If your claim has not been processed by then, payment from you is expected for the total amount of the claim submitted. I acknowledge that I have been given access to / received a copy of Kennedy Vision Health Center's HIPPA notice of privacy practices. **Form must be signed to authorize claim filing.**

Authorized Signature: _____Date: _____/_____/_____
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