Lakeside Vision Patient Information Form

Amy M. Neal, O.D., Michael R. Neal, O.D., Doctors of Optometry

ALL INFORMATION MUST BE COMPLETED BEFORE DOCTOR CAN BE SEEN

Mr. Mrs. Ms. Miss Master (*please circle one*) Patients Name:	Age:	Sex: M F	Birth date: - -

Who may we thank for referring you to us?	Social Security #:	Marital Status: (*please circle one*) Married Single Partner Divorced Widowed

Mailing Address:	City:	State:	Zip:

Home Telephone #:	Daytime Telephone #:	Cell Phone# Text OK? Y/N	E-mail Address:

Student: Full-Time Part-Time	Employed: Full -Time Part –Time Unemployed Disabled Retired	Employer:	Occupation:

Race: (*Please Circle One*) / Opt Out American Indian or Alaska Native/ Asian / Black or African American / Hispanic / Native Hawaiian/Other Pacific Island / White	Ethnicity: (*Please Circle One*) / Opt Out Hispanic or Latino / Native Hawaiian or Other Pacific Island / Not Hispanic or Latino	Communication Preference: Phone / Text Email / Post

Insurance Information: A copy of all insurance cards is required for filing purposes.

	Medical Insurance:	Vision Insurance:

Name of Person with Insurance: Guarantor:	Employer:

Relationship to patient:	Birth date: / /	SSN#:	Sex: M F

Mailing Address:	City:	State:	Zip:

Home Telephone #:	Daytime Telephone #:	Cell Phone#	E-mail Address:

Secondary Medical Ins. ____

Ins. Guarantor for Secondary Ins: ____ Phone: ______________________

Address: _______________ City: ___________ State____ Birth Date: _________ SSN#_______________ Sex: M F

Primary Care Physician Information Required:

Primary Care Physician Name: ____

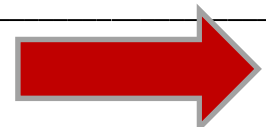
Address: ____

City, State, Zip: ____

Phone #: ____

Pharmacy Name/Location: ________________/_______________ Phone#________________________________

ALL COPAYS ARE DUE SAME DAY AS SERVICE



Patient Responsibility

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, routine examination, refraction, testing, contact lens services and any other screening ordered by the doctor or staff.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full. In the event that a statement for services rendered by Lakeside Vision is not paid within ninety (90) days of the service date, Lakeside Vision has the right to send my account to a collection agency for further follow up and collection of such debt. *Patient initials stating they understand the above information:* ___________

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment, and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. Lakeside Vision provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

SIGNATURE:____ DATE:__________________________

*Print Name:*____

Name of Person Finacially Responsible for All Billing: ____

Signature: ____

I authorize the following person/people to have full knowledge of my medical, financial, and diagnostic diagnosis information:

Name:______________________ Phone #:_________________________

Name:______________________ Phone #:_________________________

Patient or Parent/ Guardian

Signature: ____ Date: _____________________