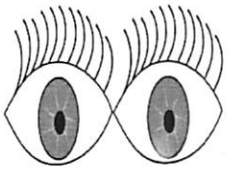

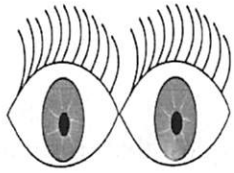

WELCOME TO
FAMILY VISION CARE

FIRST NAME: _____ LAST NAME: _____

DATE OF BIRTH _____

ADDRESS: _____

CITY/ST/ZIP CODE_____

SOCIAL SECURITY # _____HOME PHONE #:_____

CELL PHONE: ( ) _____ EMAIL:_____

We use text and email for appointment confirmation and office communications. We never share your information. We do not use it for marketing purpose.

***Please provide front desk with your insurance cards and ID**

FAMILY DOCTOR: _____

VISION INSURANCE: ID # _____

MEDICAL INSURANCE: ID #_____

PATIENT'S RELATIONSHIP TO INSURANCE HOLDER: SELF SPOUSE CHILD

Does your MEDICAL insurance require REFERRAL for special visit: YES NO

If you have a secondary insurance please list it here _____

Please list all current medication:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you wear glasses? ___yes____no

Do you wear contact lens? ____yes___no

If no, are you interested in trying contact lenses? ____yes __no

INSURANCE SIGNATURE AUTHORIZATION

I request that payment of authorized insurance benefits be made on my behalf to Family Vision Care, for services furnished to me. I authorize Family Vision Care to release to my insurance company any information needed to determined benefits payable for related service. I understand that Family Vision Care provides both routine eye examination and medical (health) eye care. When applicable, Family Vision Care will bill in-network routine eye examination insurance (such as vsp or eyemed) for routine eye examinations. However, if medical eye condition (such as glaucoma, eye injury or infection, dry eye or other conditions) requires, evalution, testing, treatment, Family Vision Care must bill you medical insurance in accordance with insurance contractual agreement. It is possible that both routine and your medical plans could be billed for one visit depending on the testing performed. **I understand that I am responsible for any co-pays, co-insurance, and non covered service or products, and deductibles required by my insurance plans.**

Signature: _____ Date: _____

Examination fees and all co-payments are due at the time of service. All products must be paid in full before they are ordered.
Refunds will not be given on services, customized ophthalmic materials or contact lenses. Upgrades will be not refunded.

Financial responsibility:

By signing this statement you agree to be financially responsible for all charges. If an account goes unpaid, a finance charge of 1.50% per month is applied to balance 60 past due. A fee up to 33.33% is added to accounts sent out to collections. All returned NSF checks will be charge a service fee of $25.

Authorization to release medical information:

I authorize **family vision care** to release/request medical information on my behalf to/from any entity to assist in my medical care per my request. I also authorize my insurance carrier to make payment directly to **family vision care.** This assignment will remain in effect until revoked by writing.

HIPPA COMPLIANCE ACKNOWLEGDEMENT OF RECEIPT

I acknowledge that I have reviewed a copy of the Notice of Privacy Practices of this office. (The front desk wall)

Signature: _____ Date: _____