Welcome to Deer Park Vision

PATIENT'S NAME: _____ Gender: □ M □ F Date of Birth:_____

Language Preference: □ English □ Other:_____ Ethnicity: □ Not Hispanic or Latino □ Hispanic or Latino

Race: □ American Indian or Alaskan Native □ Asian □ Black or African American

□ Native Hawaiian or Pacific Islander □ White □ Other _____

Mailing Address:_____City_____ State_____ Zip_____

Home Phone:_____ Cell Phone:_____Work Phone:_____

Email:_____

Communication Preference: □ Cell Phone □ Work Phone □ Home Phone □ Text □ Email □ Mail

Marital Status _____ Employer:_____ Occupation:_____

Social Security Number:_____ Is this your first visit to our office? □ YES □ NO

Whom may we thank for referring you to us?_____

PAYMENT INFORMATION

Please bring cards for all insurance companies you are subscribed with. We will copy them for your charts. Without insurance information, we cannot bill for your visit and you will be responsible for payment at the time of service.

Please list your **VISION** insurance:_____Subscriber's Name:_____

Subscriber's Date of Birth:_____ Member's ID or Social Security Number:_____

Subscriber's Employer:_____ Subscriber's Phone: _____

Please list you **MAJOR MEDICAL** insurance company:_____

Subscriber's Name:_____Subscriber's Date of Birth:_____

Member's ID or SS Number:_____

Subscriber's Employer:_____ Subscriber's Phone: _____

Who is responsible for payment? □ I AM □ OTHER:_____

INFORMATION RELEASE CONSENT

I request that payment for Medicare/Insurance benefits be made to me, or on my behalf, to Deer Park Vision for any services furnished by us.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

I clearly understand that all services rendered me are charged directly to me and that I am personally responsible for payment. I am also responsible for collection fees and attorney fees involved in the collection of my charges should that become necessary.

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 to my insurance company for the purpose of Health Care Operations (including, but not limited to, provider review functions, claims payments and quality assessments.) I also understand that I may revoke this consent by written request at any time. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

I understand that I have the right to restrict the disclosure of specific information in my medical records if I request such restriction in writing. I also understand that my request for restriction may be denied if the information restricted is required for Health Care Operations. I have read the above and foregoing consent for release of information. I do hereby acknowledge that I am familiar with and fully understand the terms and conditions of the consent.

(Initials) _____ I have received a copy of Deer Park Vision's <u>Notice of Privacy Practices</u>.

Signature: _____Date: _____

* If you choose not to consent to the above, we will still be happy to provide services for you; however, you will be required to pay for all services in advance.