

PATIENT INFORMATION

Name: _____ Title: _____ Pronouns: _____
Mr. Ms. Mrs. etc.
Nickname: _____ Date of Birth: _____ Age: _____ SSN Last 4: _____
Address: _____
City: _____ State: _____ Zip: _____
Home (____) _____ Cell (____) _____ Work (____) _____ X
Employer: _____ For Minor, Parent/Legal Guardian's Name: _____

How would you prefer to be contacted? PHONE TEXT EMAIL MAIL
May we send you text messages? YES NO

Email:

How did you hear about our office? family/friend location insurance internet professional referral

Whom may we thank for referring you to us? _____

Insurance Information

Vision Insurance: _____

Name of Primary Insured (if other than patient): _____ Relation: _____

Date of Birth: _____

Social Security # or ID: _____ Employer: _____

Medical Insurance: Medicare Aetna Premera Regence Blue Cross Blue Shield United Health
Other _____

Insurance Authorization, Release and HIPAA

I hereby authorize my insurance benefits to be paid directly to Envision Optometry. I authorize Envision Optometry to release any information required for the claim. I understand as a courtesy, Envision Optometry will estimate my insurance coverage. However, I am responsible for knowing the limitations of my insurance benefits as well as eligibility for coverage. Should my insurance deny my claim or eligibility for coverage, I am responsible for all fees accrued on my behalf.

In consideration of the service rendered to me by Envision Optometry, I am obligated to pay said office in accordance with its credit terms and policy. In the event a collection action should be required, I agree to pay the costs of collection including, but not limited to, the collection fees, court costs and reasonable attorney fees.

I am aware that prescription lenses are made to order and due to their custom nature, there are NO REFUNDS on lenses. Orders must be cancelled within 24 hours of being placed.

I authorize the release of information from my medical records if requested by Dr. Angela Lin in relationship to my health care.

I have been given an opportunity to read and/or receive a copy of the Notice of Privacy Practice Acknowledgement and Release of Information Authorization.

I have read, understand, and agree to the above,

Signature _____ Date _____