INDEPENDENCE
FAMILY EYE CARE

Marcia E. Bray, OD

WELCOME FORM

Patient Name _____ Patient's SSN_____-_____-_____
Last First M.I.

Address _____ D.O.B.____/____/____ Age____ Sex: M or F
Street Apt#

_____ Marital Status:
City State Zip
__Single __Married __Divorced __Widowed

Home Phone ( )_____-_____ Cell Phone ( )_____-_____

Email address: _____ How do you prefer to be contacted? ❑ Mail ❑ Email ❑ Home Phone ❑ Cell phone ❑ Text

Primary Care Doctor _____ Phone ( )_____-_____
Name

Emergency Contact_____ Phone ( )_____-_____
Name

Who is financially responsible for these services? __Self __Spouse __Parent/Guardian __Other

If responsible party is someone other than you, please provide their name and ssn in the space provided.

_____ _____
Full Name SSN

Patient/Parent Employer Information

Company _____

Occupation _____

Work Phone ( )_____-_____ Ext_____

Spouse/Responsible Party Employer Information

Company _____

Occupation_____

Work Phone ( )_____-_____ Ext_____

INSURANCE INFORMATION

YOU MUST PROVIDE A COPY OF YOUR MEDICAL INSURANCE CARD AND A PHOTO ID

Will services be: filed with insurance____ or self pay ____?

Is there a separate vision plan? Yes/No If yes, vision plan name _____

Primary Medical Insurance Coverage

Name of Insurance _____

Name of Subscriber_____

SSN_____-_____-_____ D.O.B._____/_____/_____

Secondary Medical Insurance Coverage

Name of Insurance _____

Name of Subscriber_____

SSN_____-_____-_____ D.O.B._____/_____/_____

Who referred you to us? _____
Name

Notice of Privacy Policies

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The Notice of Privacy Practices you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. The use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; (4) other aspects of payment described in our Notice of Privacy Policies. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You may obtain an updated copy here at the office (or from our website).

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform health care operations. You also signify that you have received a copy of this Notice of Privacy Practices.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our Notice of Privacy Practices, we are not obliged to agree to these suggested restrictions. I understand my request may be denied if the information is required for healthcare operations.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from Independence Family Eye Care.

Payment Policy

It is our mission to provide you with the highest quality eye care. In order to do this we must receive payment for our services in a timely manner. Our policy is to collect payment at the time of service. We will file medical insurance for you when we are members of the provider panel. If we are not members, you will be required to pay for your services and/or products and then file for any reimbursement. If you have not met your insurance deductible, you will be required to pay for all products and services. We accept cash, personal check, money orders, Visa, MasterCard, Discover and American Express. We are available to discuss any questions or concerns that you may have regarding our payment and collection policy. We appreciate you as a patient and thank you for allowing us to continue to provide the highest quality eye care.

Acknowledgement of Privacy & Payment Policies:

_____	_____	_____
Responsible Party Signature	Relationship to patient	Date

Please print patient name here. _____