Welcome to Envision Eyecare

PATIENT INFORMATION

First Name _____MI ____ Last Name _____ Called Name_____

Address _____ Home Phone_____ ☐ Texting OK

City _____State_____Zip_____ Work Phone_____ ☐ Texting OK

Date of Birth _____ Gender: M / F Cell Phone_____ ☐ Texting OK

SSN _____ E-mail _____

Martial Status: Single / Married / Other Spouse's Name_____

Student: FT / PT Employed: FT / PT Employer _____

Occupation _____

How did you hear about us? _____ If referred, whom may we thank? _____

Responsible Party (other than above): _____

Date of Birth_____ SSN _____ Phone_____

Address _____ City, ST, Zip_____

INSURANCE INFORMATION

VISION: _____

ID #_____Group #_____

Primary Insured: ☐ Self ☐ Spouse ☐ Other_____

MEDICAL: _____

ID #_____ Group #_____

Primary Insured: ☐ Self ☐ Spouse ☐ Other_____

If not self, Primary Insured's information:

Name _____ Date of Birth_____ SSN_____

Address_____ City, ST, Zip _____ Phone_____

OFFICE POLICIES

☐ Payment is requested for patient's responsibility of *Doctor Services* on the day of your visit.
☐ Payment is requested for patient's responsibility of *contacts* at the time of ordering.
☐ Payment is also requested for *half down* of patient's responsibility of *glasses* when ordering and the remaining balance before picking them up.

We will submit charges to your insurance carrier when complete information has been received. If insurance payment is delayed over 45 days, you will be expected to pay the balance. We will make all efforts to resolve issues for non-payment from your carrier. Any payments received from your insurance carrier after you have paid will be refunded to you immediately upon receipt of overpayment. All disputes of coverage with the insurance company are your responsibility to resolve.

I have read and understand all policies listed above. I understand that I am responsible for payment in full for all charges from this office regardless of insurance coverage. I hereby authorize my insurance benefits to be paid directly to Envision Eyecare. I am financially responsible for non-covered services and understand that payment is expected at time of service.

I acknowledge that I was given an opportunity to review Envision Eyecare's Notice of Privacy Practices.

I agree to receive messages from this office at any phone numbers listed in my chart.
I agree to receive written reminders and bills at the address listed in my chart.

_____ _____ _____

Print patient name | Signature of responsible party | Date