Family EyeCare of Virginia, Optometry

Welcome to Our Practice

Patient Information				
Patient Information	Last Name:	First Name: M.I.:		Previous Name (if applicable):
	Mailing Address:			
	City/State/Zip:			
	Home Phone:	Cell Phone:	Work Phone:	
	Date of Birth:	Social Security #:	Email:	
	Employer Name:	Occupation:		
	Emergency Contact:	Emergency Contact Phone:	Relationship to patient:	
	How did you hear about us?:	Whom may we thank for referring you?:		
Responsible Party - If the patient is under the age of 18, the parent or guardian bringing the patient in will be listed as the guarantor				
Responsible Party	Last Name:	First Name: M.I.:		Previous Name (if applicable):
	Mailing Address:			
	City/State/Zip:			
	Date of Birth:	Social Security #:	Phone:	
	Relationship to Patient:	Email:		

Insurance Information		
Insurance Information	**Primary Medical Insurance**	**Secondary Medical Insurance**
	Insurance Company Name:	Insurance Company Name:
	Member ID Number:	Member ID Number:
	Policy Holder Name:	Policy Holder Name:
	Policy Holder Date of Birth:	Policy Holder Date of Birth:
	Policy Holder Social Security #:	Policy Holder Social Security #:
	Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

Office Financial Policy & Insurance Authorization:

We are committed to providing you the highest eye care possible as well as maintaining the privacy of your health information and medical records. All exam fees & co-pays are due at the time of service. Please understand that you are fully responsible for all charges whether or not they are covered by insurance. By signing below, you are giving us authorization to file your charges with the insurance company. You are also authorizing us to release any information about you to the insurance company in order to get reimbursement for services rendered to you. Accounts not settled within 60 days may incur a 1.5% finance charge per month as well as a 33% collection fee. Returned checks will be charged a $20 fee. Inactive medical records will be stored in our office for a maximum of five years from the last date of service. After this time they will be disposed of in a secure manner in accordance with State of Virginia regulations.

I have read, understand and agree to the above financial policy and insurance authorization. I also acknowledge that I have been offered a copy of the Notice of Privacy Policy (HIPPA) for review.

Patient Signature: _____ Date: _____