Patient Information

Name: ______________________________________ Date of Birth: ___________ M__ F__

Address: ____

City: _____________________________________ State: _______ Zip Code: ____________

Home Ph: _________________ Work Ph: _______________ Cell Ph: _________________

Email: ____

Social Security Number: ______________________________

Medical Insurance (Primary): _________________________ ID#: ____________________

Secondary Insurance: __________________________ ID#: ____________________

Name of Primary Cardholder: _________________________ DOB: ___/___/_____

Vision Insurance (Primary): ________________________ ID#: _______________________

Secondary Insurance: ________________________ ID#: _______________________

Name of Primary Cardholder: _________________________ DOB: ___/___/_____

Preferred Pharmacy & Location: ____

Pharmacy Phone#: ____

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits to Fallas Family Vision, including major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment check(s) directly to Fallas Family Vision for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Fallas Family Vision to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Fallas Family Vision on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____________________________________ ____________

Patient/Responsible Party Signature Date

HIPAA

Acknowledgment of Receipt of Privacy Notice

By signing this Acknowledgment of Receipt of Privacy Notice, I acknowledge that I have read over and agree to the terms outlined by the Notice of Privacy Practices. I understand that a copy of the Notice of Privacy Practices can be furnished to me at my request at any time.

I understand that Fallas Family Vision may use and disclose necessary personal information (for example, my name, address, insurance information, eye exam notes, and types of products provided) to another party to permit them to perform their administrative duties, provide me with eye care services and products, process my vision benefit claims and communicate with me (for example, mailings and reminders).

I can be assured that Fallas Family Vision does not sell my personal health information of any kind to a third party for such party's own use. I authorize them to submit my vision benefit claims to my plan sponsor or health plan to receive reimbursement directly for the vision services and products that I have received from them.

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Patient Signature or Patient's Legal Respresentative Date