WELCOME TO OUR OFFICE

Name_____ □M _____ _____ _____-_____-_____
Last First MI □F Nickname Date of Birth Social Security #

_____ _____ _____ _____
Street Address Home Phone # Work Phone # Cell Phone #

_____ _____ _____ _____
City State Zip Employer/School Spouse/Parent's name Spouse's Employer

What are the names and ages of your children still living at home?_____

_____

Do you prefer to be contacted: □At Home □At Work □By Cell
E-Mail Address:_____

Who may we thank for referring you to our office?_____
Name of Friend or Relative

If not referred, how did you choose our office for your needs? □Saw sign/Building □Insurance List □Newspaper □Radio □Another Dr. □Yellow Pages: Which Directory? _____□ Web Site?_____□ Other?_____

INSURANCE INFORMATION:

Vision Insurance_____ **Primary Medical Insurance**_____

Subscriber Name_____ Subscriber Name_____

Subscriber ID#_____ Subscriber ID#_____

Subscriber Birth Date_____ Subscriber Birth Date_____

Do you participate in a flex spending account? □ Yes □ No

How will you settle your account today? □Cash □Check □Credit Card □Debit Card

Monthly interest charges of one and a half percent (1 ½%) per month or eighteen percent (18%) per year will accrue thirty (30) days after billing. The undersigned shall assume the responsibility for a ten percent (10%) collection agency fee if referred to a collection agency, attorney fees, court costs, and other costs incurred in an attempt to collect payment. All returned checks will be charged a $30 fee.

We are required by law to maintain the privacy of, and provide individuals with, our HIPAA Notice of Privacy Practices which outlines our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices._____ (Please initial)

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Mooresville Family Eye Care, P.C. on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration or my Insurance Company and its agents any information needed to determine these benefits payable to related services.

Lifetime Patient Signature:_____ Date:_____