

Welcome to Our Office

For faster service, please complete the form prior to arriving at our office.

Appointment Date _____

Patient's Name (please print) _____

If a Child, Parent's Name _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

E-Mail Address _____

Birth Date _____ M or F (circle) Social Security Number _____

Employer _____ Occupation _____

Vision Insurance Carrier _____ Policy # _____

Medical Insurance Carrier _____ Policy # _____

Policy Holders Name _____ Date of Birth _____

How did you find out about our office? _____

I understand that HIPPA federal regulations strictly forbid this practice to share my protected health information with any other individual without my permission. Therefore, I give this practice permission to share my protected health information with the following individuals. I also know that I have the right to cancel this permission at anytime in writing.

Name _____ Relationship _____

Signature _____ Date _____

AUTHORIZATION, ASSIGNMENT, AND RESPONSIBILITY OF ACCOUNT

I hereby authorize Dr. Szczepanski/Healthy Vision to release to the above insurance companies and/or their intermediaries or carriers any medical information needed for claims reimbursement. I hereby acknowledge and accept responsibility for payment in full of all services rendered to me.

Signature _____ Date _____