PEDIATRIC

DATE _____

Recorded by_____

Welcome to our practice!

Thank you for choosing Family Vision Care for your eye care needs

PATIENT INFORMATION-PLEASE PRINT

Patient Name _____ Birth Date _____
First MI Last

Nickname/prefers to be called: _____ □ Male □ Female

Address _____ City_____ State _____ Zip_____

Home phone # _____ Parent Cell #_____ Other phone # _____

Preferred method of contact: □ E-mail □ Text □ Cell Phone □ Home Phone

Parents' Name(s) _____ Parent Work # _____ Parent Employer _____

Parent email address_____

(We do not share your information. E-mails are used for information directly from our office and for appointment scheduling & confirmation.)

Person to contact in case of emergency _____Emergency Contact Phone # _____

List other family members seen by us _____

How did you hear about us? (please check all that apply) □ *Referral from relative/friend/doctor/co-worker*

□ *Parent Magazine* □ *Driving by* □ *Insurance list* □ *Internet* □ *Other* _____

Who should we thank for referring you to us? _____

RESPONSIBLE PARTY & INSURANCE INFORMATION

Please present all insurance cards at reception desk

Name of primary policyholder/ Person responsible for this account _____

Relationship to patient_____ Birth Date _____ Social Security #_____

Address _____ City _____ State _____ Zip _____

Home phone #_____Work phone # _____ Other phone # _____

Responsible party's employer _____ Occupation_____

DOES RESPONSIBLE PARTY HAVE **VISION** INSURANCE? □ Yes □ No Insurance Company _____

DOES RESPONSIBLE PARTY HAVE **MEDICAL** INSURANCE? □ Yes □ No Insurance Company _____
(If you have Medicare, please provide that information here)

DOES RESPONSIBLE PARTY HAVE ADDITIONAL INSURANCE? □ Yes □ No Insurance Company _____

☺ Please turn this form over and complete side 2 – thanks! ☺

Acknowledgement of Receipt - Notice of Privacy Policy & Practices

I understand that in an attempt to protect the privacy of my identifiable health information, Family Vision Care of Cool Springs has established a privacy policy and guidelines for privacy practices within their office. This information details the use and/or disclosure of information contained in my personal medical/optometric records kept for the purposes of diagnosis, treatment, payment, and health care operations. In accordance with HIPAA Regulations, a copy of Family Vision Care of Cool Springs' Privacy Policy & Practices has been made available to me while in the office today.

_____ _____

Signature of Patient/Guardian Date

Financial Agreement and Insurance Authorization

I, the undersigned, understand that *I am financially responsible for payment of services rendered to me or my dependents at time of service and am also responsible for paying any co-payments, deductibles, and services that my insurance does not cover after insurance claims have been filed.* I understand that statements for patient balances are due upon receipt unless payment arrangements have been made within 30 days. I understand that, if my account remains unpaid for 90 days or more, it will be turned over to a third party collection service, and I will be responsible for all additional fees/charges from the collection service. I authorize and request my insurance company (including Medicare) to assign directly to Dr. Dunn or Dr. Weldon all medical benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured/Guardian Date

Appointment Cancellation Policy Agreement:

Family Vision Care is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us at 615-771-2550 by 2:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. **To cancel a *Monday* appointment, please call our office by 2:00 p.m. on *Friday*.** If prior notification is not given, you will be charged $75 for the missed appointment.

_____ _____

Signature of Patient/Guardian Date

Authorization to Reveal Medical and Billing Information

I authorize Family Vision Care of Cool Springs to reveal the following individuals, as needed, information regarding my health and billing information. I understand that Family Vision Care of Cool Springs will not have responsibility over to whom these individuals reveal this information. I may revoke this authorization at any time by giving a written notice to Family Vision Care of Cool Springs.

Name _____ Relationship_____

Name _____ Relationship_____

_____ _____

Signature of Patient/Guardian Date