

Patient Welcome Form

Nickname:	DOB:	Gender:	Today's Date:
First Name:	Middle Name:	Last Name:	
Marital Status:		<input type="checkbox"/> Employed <input type="checkbox"/> Student: <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time <input type="checkbox"/> Other	
Address:		City:	Zip:
Home Phone:	Work Phone:	Cell Phone:	Other Phone:
Email:		Preferred Contact Method: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Other	
Social Security Number:		Employer/ School:	
Guardian(s) and Relationship to Patient:		Primary Care Doctor:	
Emergency Contact (Name, Phone Number and Relationship to Patient):			
May we leave DETAILED messages? <input type="checkbox"/> No YES, Regarding: <input type="checkbox"/> Appointments <input type="checkbox"/> Billing <input type="checkbox"/> Medical <input type="checkbox"/> All			

Insurance Information

Primary Insurance: ID: Group#:	Subscriber Name: Employer: DOB: Relationship to Insured:
Vision: Yes/No	
Secondary Insurance: ID: Group #:	Subscriber Name: Employer: DOB: Relationship to Insured:
Vision: Yes/No	
Additional Insurance: ID: Group #:	Subscriber Name: DOB: Employer: Relationship to Insured:
Vision: Yes/No	

Please read and sign below:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. Visions of Washington as a courtesy has tried to obtain as much information as we can prior to your appointment start time. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to Visions of Washington. I understand that my insurance company (or companies) will be billed. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Patient Signature, or Guardian if 18 years or younger

Date

Visions of Washington

Bartlett Eye Clinic

*

Everett Family Vision

*

Magnolia Eye Care

Patient Name: _____

Acknowledgement of Receipt of Notice of Privacy Practices

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The **Notice of Privacy Practices** you have been given describes these uses and disclosures in detail.

Authorization to Treat

I hereby give Everett Family Vision and its associate's permission for evaluation and treatment of myself and/or my dependent. I authorize Everett Family Vision to release all medical and/or insurance claim information to secure payments.

Cancellation Policy

Please note that any missed appointments without a cancellation call with at least 24 hours advanced notice are subject to a cancellation fee.

I acknowledge that I have received the *Notice of Privacy Practices* from Everett Family Vision, that I am giving authorization to treat myself and/or my dependent, and that I agree to the cancellation policies of the office.

Signature, or Guardian if 17 years or younger

Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to Patient

Print Name

Optional Quick Pay Consent Form:

Cardholder Name:

Cardholder Address:

City/State:

Zip Code:

Card Type (circle):

VISA

MasterCard

CheckCard

Other

CC Number:

Expiration:

Cardholder Signature:

Automatically charge all balances.

Call, I may want to pay by check.

Please provide written cancellation to end your quick pay agreement. It will be necessary to contact the office to adjust any changes to your card information, should changes occur.