CARLISLE Vision Clinic

Section I: **Patient Information** **Date**_____

Name:_____ I Prefer to be called: _____

Address:_____City:_____State:_____Zip_____

Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____

Date of Birth:_____ Social Security Number:_____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Employer:_____

Email Address:_____

Emergency contact:_____ Relation to patient: _____ Phone:_____

Ethnicity: ☐ Hispanic or Latino ☐ Native Hawaiian/Other Pacific Island ☐ Not Hispanic or Latino

Race: ☐ American Indian or Alaska Native / ☐ Asian / ☐ African American / ☐ Caucasian / ☐ Hispanic / ☐ Native Hawaiian/Other Pacific Island

Communication Preference: ☐ Email ☐ Postal ☐ Telephone

Section II **Responsible Party**

Relationship to Patient: ☐ Self **(IF SELF SKIP TO SECTION III)** ☐ Spouse ☐ Parent ☐ Other

Name:_____ Relationship to Patient: _____

Mailing Address:_____

City:_____State:_____ Zip:_____ Phone: (____)_____

Employer_____ Work Phone (____)_____ SSN#_____

Section III **Insurance Information**

Name of Insured_____ Relationship to Patient _____

DOB_____ Age _____ SSN#_____ Phone _____

Medical Insurance_____ ID #_____ Group #_____

Secondary Insurance _____ ID # _____

Vision Insurance _____

Section IV

Insurance Authorization and Assignment: I request that payment of authorized private insurance company benefits, Medicare and Medicaid services, or other applicable benefits be paid on my behalf to Dr. Carlisle of Carlisle Vision Clinic for any services provided. I authorize Carlisle Vision Clinic to release any medical or other information about me to any private insurance company, Medicare and Medicaid, or other company and its agents which might provide coverage to me.

All Services are the Responsibility of the Patient: Carlisle Vision Clinic will gladly bill all primary insurances we are providers of. I understand that insurance benefits must be determined prior to my exam. If I become aware of insurance coverage after services have been rendered, I agree to personally submit the claim to my insurance company for reimbursement. I understand that when my insurance company requires a referral from my primary care physician, and I do not furnish the correct referral at the time of service, I will be responsible for payment if my insurance company refuses my claim. I also understand and acknowledge that I am financially responsible for non-covered services and any unpaid insurance balances.

Payments, Co-pays, and Deductibles are Due at Time of Service: I understand that not all services and materials may be covered by my insurance or may exceed benefits or coverage. I agree to pay all payments, co-pays, and deductibles at the time of service for all services and materials.

Returned Checks: There is a $25.00 fee for any check returned by the bank. This fee will be added to the unpaid balance and must be paid by cash or credit card.

Section V

Notice of Privacy Practices: I acknowledge I have been offered a copy of Carlisle Vision Clinic's Notice of Privacy Practices.

☐ Yes, I would like to receive a copy of Carlisle Vision Clinic's Notice of Privacy Practices.

☐ No, I do not wish to receive a copy of Carlisle Vision Clinic's Notice of Privacy Practices.

I hereby acknowledge all of the above information is correct to the best of my knowledge.

Signature:_____ Date:_____