NORTHSIDE VISION

PATIENT CONTACT & PAYMENT FORM

CONTACT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Preferred Name: _____ ☐ Male ☐ Female ☐ Other ☐ Single ☐ Married ☐ Other

Birthdate: _____ SS#: _____

Mobile Phone/Text: _____ E-Mail: _____

Home Phone: _____ Work Phone: _____

Address: _____ City: _____ State/Zip: _____

Patient's Occupation: _____ Employer/School: _____

Spouse's/Parent's Name: _____

Name of Emergency Contact: _____ **Day Phone:** _____

PERSON RESPONSIBLE FOR ACCOUNT

If patient is responsible for own account, just list SELF.

Name: _____ SS#: _____

Address: _____

City: _____ State/Zip: _____ Home Phone: _____

Relationship to Patient: _____ Employer/School: _____

INSURANCE INFORMATION

Vision Insurance Company: _____ Insured's ID#: _____

Insured's Name: _____ Relationship to Patient: _____

Birthdate of Insured: _____ SS#: _____ Employer Name: _____

Primary Medical Insurance Company: _____ Insured's ID#: _____

Insured's Name: _____ Relationship to Patient: _____

Birthdate of Insured: _____ SS#: _____ Employer Name: _____

ASSIGNMENT & AUTHORIZATION

1. I am financially responsible for all charges whether or not paid by insurance. I understand that Northside Vision will bill my insurance as a courtesy to me, but Northside Vision is not responsible for collecting or negotiating settlements with my insurance carrier(s). I hereby authorize my insurance company(s) to pay Northside Vision directly.
2. Additional procedures and services may be deemed medically necessary. These additional services will be discussed with me prior to being performed. I hereby authorize the physician and/or assistants to administer any treatment as may be deemed necessary. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of my examination or treatments performed.
3. All optical materials require a 50% deposit at the time of ordering, with the balance due at time of delivery.
4. Northside Vision may disclose health information to my insurance company and their agents for the purpose of determining insurance benefits and obtaining payment for services rendered. Contact lens services are NOT included in a routine eye examination and will be billed as a separate charge.
5. A $50 service charge will be assessed on all NSF checks.
6. Privacy practices have been established to comply with the privacy rules under the Health Insurance Portability And Accountability Act (HIPAA). I have been informed of my right to view Northside Vision's HIPAA policies.

Signature: _____ **Date:** _____