



WELCOME TO  
SUMNER VISION

CHILDREN WELCOME

# Welcome To Our Office

Please Complete All Parts



Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Email Address \_\_\_\_\_ Gender:  M  F Work Phone \_\_\_\_\_  
 Occupation \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 How do you prefer to be addressed by the office staff? \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Please List Your Family Members and their Ages \_\_\_\_\_ Best Time & # To Reach You: \_\_\_\_\_  
 \_\_\_\_\_ Date of Last Visit \_\_\_\_\_  
 How did you choose our office? \_\_\_\_\_ Name of Primary Care Physician \_\_\_\_\_  
 What is the reason for seeking eyecare at this time? \_\_\_\_\_ Are you purchasing eyeglasses or  
 Relationship to responsible party:  Self  Spouse  Son  Daughter  Other \_\_\_\_\_ contact lenses today?  Y  N

## RESPONSIBLE PARTY (Person who should receive this bill) Check here if same as above

Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_ Gender:  M  F Date \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Email Address \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Occupation \_\_\_\_\_ Social Security # \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Best Time & # To Call: \_\_\_\_\_

## PRIMARY MEDICAL INSURANCE (This is usually different from your Vision Insurance)

We will need a copy of your medical insurance card, if medical eyecare is provided.

Insurance Company \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State/Zip \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Primary Insured Person \_\_\_\_\_

## IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name \_\_\_\_\_  
 Relationship \_\_\_\_\_  
 Phone \_\_\_\_\_

## CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by **SUMNER VISION** for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct health care operations of **SUMNER VISION**. I understand that diagnosis or treatment of me by **SUMNER VISION** may be conditioned upon my consent as evidenced by my signature on this document.

INITIALS \_\_\_\_\_

I give **SUMNER VISION** permission to leave all appointments, lab results, test results, and other medical information and advice on: (check all that apply)

- Voice mail at work  Answering machine at home  Cell Phone  Okay to leave message with family member  Do not leave message  
 Other: \_\_\_\_\_

INITIALS \_\_\_\_\_

I have the right to revoke this consent, in writing at anytime, except to the extent that **SUMNER VISION** has taken action in reliance on this consent.

INITIALS \_\_\_\_\_

I hereby acknowledge that I have received, or been offered a copy of the **SUMNER VISION** Notice of Privacy Practices. I authorize the release of any medical information and payment of medical benefits to the undersigned physician or supplier for services necessary to process a claim. I agree to be responsible for any deductible, co-insurance, co-pay, or any other balance not paid by my insurance.

INITIALS \_\_\_\_\_

If an insurance company refuses to pay for my services, I agree to pay **SUMNER VISION** for these services.

INITIALS \_\_\_\_\_

Office policy calls for payment at time of service. ALL insurance co-pays on services and products are due at time of service. We accept cash, personal checks, and credit cards. A monthly billing fee of \$5.00 is added to all accounts with an unpaid balance after 30 days. I have read and agree to all the provisions in the consent, privacy, and financial policies of the office.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
NAME OF PATIENT OR PERSONAL REPRESENTATIVE