PATIENT WELCOME FORM

NAME (Last, First, MI - Title)**:**_____

SEX: M F **LEGAL STATUS:** Minor Single Married Divorced Separated Widowed

BIRTH DATE (MO/DAY/YEAR)**:**_____ **S.S. #:**_____

STREET ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE 1 – TYPE: _____ **PHONE 2 – TYPE:** _____

EMAIL 1:_____ **EMAIL 2:**_____

PREFERRED CONTACT: Phone 1 or 2 – Email 1 or 2 – Text - Other (explain) _____

May we contact you via Email versus postcard for you exam recall notification? Yes No

EMERGENCY CONTACT / PERSON & PHONE: _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

RESPONSIBLE PARENT OR GUARDIAN MUST COMPLETE IF MINOR PATIENT

PARENT OR GUARDIAN NAME: _____

PARENT OR GUARDIAN DATE OF BIRTH: _____ **S.S. #** _____

WE WILL REQUIRE A COPY OF ALL VISION AND MAJOR MEDICAL INSURANCE CARD(S) AT TIME OF APPOINTMENT

VISION INSURANCE: _____

VISION INSURANCE MEMBER NAME: _____

MEMBER DATE OF BIRTH: _____ **MEMBER S.S. #** _____

PRIMARY MEDICAL INSURANCE: _____

PRIMARY MEDICAL INSURANCE MEMBER NAME: _____

PRIMARY MEMBER DATE OF BIRTH: _____ **PRIMARY MEMBER S.S. #:**_____

RELATIONSHIP TO PRIMARY MEMBER: Spouse – Child – Other (explain) _____

SECONDARY MEDICAL INSURANCE: _____

SECONDARY MEDICAL INSURANCE MEMBER NAME: _____

SECONDARY MEMBER DATE OF BIRTH: _____ **SECONDARY MEMBER S.S. #:**_____

RELATIONSHIP TO SECONDARY MEMBER: Spouse – Child – Other (explain) _____

Please read our Financial Policy & Consent to Treat on the other side and sign all 3 areas.

ASSIGNMENT & RELEASE *(Please read and sign)*

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Miller all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. 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 insurance submissions.

Responsible party signature: _____ Relationship: _____

Date: _____

FINANCIAL POLICY *(Please read and sign)*

All exam fees are due the day of the examination. If you have vision insurance, it is our policy to bill your insurance carrier as a courtesy to you. You are liable for all co-payments and deductibles on the day of the examination. Optional charges ordered require a payment of half down on the day of order, with balance due at the time of dispensing. Our office accepts cash, check, credit cards and Care Credit.

If insurance denies your claim for service and/or materials for being ineligible or not covered you are responsible for the bill. It is not our policy to contact your insurance company to establish why they have denied, not paid, or paid less than originally indicated.

I have read the above financial policy and understand it fully:

Print name: _____ Relationship: _____

Signature: _____ Date: _____

CONSENT TO TREAT

I authorize Dr. Craig A. Miller, a licensed Optometrist in the State of Michigan, to examine and treat my eyes for visual and physical ocular conditions or abnormalities that are within the scope of his legal authorization. This will involve his refractive expertise to determine the state of refraction and binocularity, the fitting of glasses or contact lenses, and the possibility of visual training and consultation. I also authorize Dr. Miller to exam and treat my eyes for conditions that may involve therapeutic and diagnostic pharmaceuticals utilized within the scope of his licensure and proficiency.

I understand that in the course of Dr. Miller providing Optometric service; he creates, receives, and stores personal health information that identifies specifically with me and that it will often be necessary that Dr. Miller use and disclose this health information in order to treat me properly, obtain payment, and for him to conduct health care operations within his office. I have read and been offered a copy of his Privacy Notice that describes these particular uses and disclosures in detail and know that I can refer to his testimony in this notice at any time before I sign this agreement. To my knowledge, if Dr. Miller updates or changes his Privacy Policy for any reason, a revised version of this policy will be available at his office and available for review.

Upon signing this agreement, I signify and concur that Dr. Miller can use or disclose my health information to treat me, obtain payment from me, and perform health care operations within his office. I can revoke this consent at any time unless Dr. Miller has already preformed any of the previously discussed procedures relative to my personal health information. Dr. Miller can elect to **not provide services to me, if I do not sign this form.** I understand that I have the right to ask Dr. Miller to restrict the use or disclosures made for the purposes of treatment, payment, or health care operations as described in his Notice of Privacy Policies, but he will not necessarily be obligated to agree. If we do concur in writing, the restrictions are binding on both parties.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

_____ _____

Patient and/or Guardian Dated

I truly appreciate your business and if my office can do anything to make your visit more comfortable and accommodating, please let me know. Dr. Miller