VISION SOURCE®

WALLA WALLA

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Text Message : Yes No Gender: _____ DOB: _____
Marital Status: _____ Primary Care Provider: _____
SSN: _____ Occupation: _____
Email: _____ Employer: _____
Primary Ins: _____ ID Number: _____
Secondary Ins: _____ ID Number: _____
Emergency contact: _____ Phone number: _____ Relationship _____

Parent or Guardian (Responsible party if not patient)

Name: _____ Relationship: _____ Phone: _____

Acknowledgment of Receipt of Privacy Policies

I acknowledge that I have been given an opportunity to review the Notices of Privacy Policies.

X _____ Date _____

Insurance Authorization and Financial Disclaimer

As a courtesy, we will gladly file insurance claims on your behalf, but the doctor cannot accept responsibility for collecting your insurance claim or negotiating a settlement on a disputed claim. Insurance reimbursement, coverage and benefits are a contract between you and your insurance carrier. You are responsible for the prompt payment of your account regardless of any pending insurance claim or settlement. You will receive a statement each month for the outstanding balance of your account, even though you have an insurance claim pending. You are responsible for the entire fee regardless of any insurance claim, determination, maximum, or limitations on benefits, including our customary fee not paid by your insurance carrier.

Be aware that benefits are not guaranteed until the claim is processed. Please read and sign the agreement below.

I request that payment for authorized insurance benefits provided be made on my behalf to:
Dr. Harry Wiessner Dr. Daniel Wiessner Dr. Rosanne Schneller

I authorize any holder of medical information about me to release to my insurance company and its agents, any information needed to secure payment of benefits for all related services. I understand that I am responsible for all charges not paid by my insurance plan. Charges not covered by insurance must be paid in full before eye wear is dispensed.

X _____ Date _____