Dr. Viviani's Total Vision Care

Thank you for choosing our practice for your eyecare needs. Please complete this form in ink. If you have any questions, do not hesitate to ask for assistance.

Patient Information:

Date:_____

Patient name_____Date of Birth_____

Last First M.I.

Residence Street Address_____

City_____State_____Zip_____

Phone home_____ cell_____work_____

Email:_____ preferred method of contact_____

Occupation_____Employer_____

Spouse's name_____Workplace_____work#_____

Emergency contact_____phone_____

Whom may we thank for referring you to us?_____

Responsible Party

Person responsible for payment of account:_____

Relationship to patient_____

Responsible Street Address_____

City_____State_____Zip_____

Name of employer_____work phone_____

Vision Plan Information

Name of plan_____member #_____

Name of insured_____ relationship to patient_____

Social security #_____ Birthdate_____

Health Insurance Information

Name of plan_____member #_____

Name of insured_____ relationship to patient_____

Social security #_____ Birthdate_____

Insurance Liability Statement

It is your responsibility to know your insurance company policy, your benefits, necessary referrals, and your current eligibility for coverage at the time services are rendered by this office. It is also your responsibility to inform this office if you have changed insurance companies or benefit plans which would effect your current eligibility for coverage. If for any reason, you are not eligible for insurance coverage at the time of your visit, you will be held financially responsible for any services and materials rendered. Once payment for services and materials has been made, NO reimbursements will be made for the discovery of insurance benefits *after the fact.*

Patient Name_____ date_____

Patient Signature (guardian)_____

(Over)

Authorization

I certify that I have read and understand the above information. I authorize the this office to release any information including the diagnosis and the records of any treatment rendered to me or my child to third party payers and/ or health practitioners. I authorized and request my insurance company to pay directly to the eye doctor benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient Name_____date_____

Patient Signature (guardian)_____