Name: _____ _____ _____
Last First M

Preferred Name: _____ Preferred Pronouns: _____

Legal Gender: ☐ Male ☐ Female Gender Identity: ☐ Male ☐ Female ☐ Non-Binary

Date of Birth: _____/_____/_____ Social Security Number: _____

Address: _____

City: _____ Zip: _____

Primary Phone: (___) ____ - _____ ☐ Home ☐ Cell ☐ Business

Alternate Phone: (___) ____ - _____ ☐ Home ☐ Cell ☐ Business

Email Address: _____

Are you: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed ☐ Separated

Employer: _____ Occupation: _____

Preferred Language: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Hispanic ☐ Native Hawaiian or Pacific Islander ☐ White or Caucasian ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Native Hawaiian or Pacific Islander ☐ Not Hispanic or Latino

How did you hear about us? _____

If a referral, who may we thank for referring you? _____

Office Policies

Thank you for choosing our practice to assist you with all your vision needs. It is our mission to provide you with quality, state of the art eye care. The following is a statement of our office policies. Please read and sign this prior to the rendering of any service.

- Full payment is due at the time of service unless we are able to accept assignment of your insurance benefits. If assignment is taken, you will still be responsible for any deductibles or copayments at the time services are rendered.
- We accept cash, checks and credit/debit cards.

REGARDING INSURANCE
As a courtesy to our patients, our practice will make every effort to accept your vision insurance, but there are times that we may not be able to do so. Your insurance policy is a contract between you and your insurance company, and if services are denied you will be responsible for the balance on your account. If your insurance has not reimbursed us for your claim within 45 days, you will automatically be responsible for the balance. Any outstanding amount over sixty days will incur a 5% monthly finance charge.

USUAL AND CUSTOMARY RATES
Our practice is committed to providing the best treatment to our patients and we charge fair rates based on the professional services that we provide.

MISSED APPOINTMENTS
We are a locally owned business and cannot absorb the losses associated with missed appointments. Please help us serve you better by keeping scheduled appointments. Unless cancelled at least 24 hours in advance, missed appointments will be assessed a fee of $50.00.

PUNCTUALITY
We do everything we can to be on time. If you have waited 10 minutes past your scheduled time please notify the front office. Please try to be on time for your appointment. If you are running late, please call the office and let us know. If there is not sufficient time to complete your scheduled appointment, your appointment may be rescheduled.

MINOR PATIENTS
The adult parent/legal guardian accompanying the minor/dependent patient must be present at each visit and is responsible for payment of the minor/dependent's account regardless of who the insurance policy holder is. For the safety of children under the age of 12, we require the supervision of an accompanying older person at all times. Our office staff cannot provide supervision for young children in the waiting area.

I HAVE READ, UNDERSTOOD, AND AGREED TO THESE OFFICE POLICIES.

_____ _____

Signature Date