HEARNE VISION CARE

PATIENT INFORMATION

Patient Name: _____ DOB: _____
First Middle Initial Last

Address: _____ Home Phone: _____
Number Street City State Zip

Email Address: _____ Social Security Number: _____

Marital Status (please circle): Single Married Divorced Separated Widowed

Place of Employment: _____ Work Phone: _____

May we contact you at your work place (please circle): Yes No

Sex (please circle): Male Female Student (please circle): Yes No

Spouse's Name: _____ Family Doctor: _____

How did you choose our practice? _____

If referred by family or a friend, please list: _____

Favorite Type of Music or Favorite Artist: _____

Emergency Contact:

Name: _____ Relationship: _____

Address: _____ Phone: _____

Responsible Party Information (if different from patient):

Name: _____ Phone: _____

Address: _____ County: _____

_____
Number Street City State Zip

Employer: _____ Occupation: _____

Address: _____ Work Phone: _____
Number Street City State Zip

Social Security Number: _____ Birthdate: _____

Insurance Information *(Some eye health conditions may be covered by your medical insurance)*:

Medical Insurance: None Aetna Anthem or BC/BS Cigna Medicare Other: _____

Name of Policyholder: _____ ID Number: _____

If you are not the policyholder, please fill out below: Group Number: _____

_____

Relationship: _____ Date of Birth: _____ SSN: _____

Employer: _____ Work Phone: _____

Vision Insurance: None Yes If yes, name of insurance: _____

I authorize Hearne Vision Care, LLC to release my patient records and other health care information identifying me to Medicare and to each of my insurance companies. Hearne Vision Care, LLC may act as my agent to file claims and obtain payment from Medicare and my insurance companies for all goods and services provided by Hearne Vision Care, LLC. I authorize Medicare and each of my insurance companies to make payment directly to Hearne Vision Care, LLC. I UNDERSTAND AND AGREE THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT FOR ALL GOODS AND SERVICES PROVIDED BY HEARNE VISION CARE, LLC REGARDLESS OF ANY INSURANCE THAT I MAY HAVE. If I do not pay Hearne Vision Care, LLC all amounts owed within 30 days of the date of Hearne Vision Care, LLC's statement mailed to me, I further agree to pay all reasonable costs and expenses in connection with the attempted collection of such amounts (including, without limitation, reasonable attorney fees, collection agency fees, court costs and all other collections costs and expenses). If the patient named above is a minor, I am making these authorizations and agreements as the person responsible for payment of all goods and services provided to such minor by Hearne Vision Care, LLC.

_____ _____
Signarture of Person Responsible For Payment Date