OPTICAL 2000 CLINTON
WELCOME TO OUR OFFICE!

Name:______________________________ Date of Birth: ___________Race: _____ Gender: ____

Street: ______________________________ City: __________ State: ____ Zip: ______

Home Phone: _______________________ Work Phone: _______________________

Cell Phone: _________________________ Email: ____________________________

Employer (School): ___________________ Occupation (Grade): __________________

Social Secruity #: _______________________

Vision Insurance: _______________________ ID #: ___________________________

Medical Insurance: ______________________ ID #: ____________________________

Card Holder Name: _____________________ Card Holder Date of Birth: ____________

We need to make copies of photo ID, medical and vision insurance cards

Optical 2000 Clinton

Patient Responsibility

I permit a copy of this authorization to be used in place of the original, and request payment of the medical insurance benefit to the medical party who accepts assignment.

I agree to be responsible for payment of services rendered not covered by my medical or vision insurance.

____ ____________________

Signature of Responsible Party Date

**If you have insurance, we will be glad to help you file for any benefits to which you are entitled. However, it remains the responsibility of the individual patients to settle their account properly.

Authorization to Release Information

I, ______________________________, hereby authorize Optical 2000 to release my medical records to the below listed people (this includes people who are allowed to pick up glasses, contacts, prescriptions, etc):

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I understand I may revoke this consent at any time in writing except to the extend that this action has been taken in good faith.

______________________________ ________________ _______________

Signature Date Relationship

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Optical 2000's Notice of Privacy Practices.

____________________	____________________	________
Name	Signature	Date