OPTICAL 2000 RICHLAND
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 Richland

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):

_____

_____

_____

_____

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