WERNER OPTOMETRY
A MEMBER OF Vision Source

□ Dr. □ Mr. □ Mrs. □ Male □ Single □ Divorced
□ Ms. □ Miss □ Female □ Married □ Widowed **Date of Birth** _____/_____/_____

Last Name _____**First Name**_____**MI**_____

Address_____ _____**City**_____ **State**_____**Zip**_____

Home # (_____)_____**Work #** (_____)_____**Cell #** (_____)_____ □ *Do not text*

Employer_____**Occupation**_____**Prefered communication:** □Text □ Email □ Phone

SSN_____-_____-_____ **How were your referred to our office?** _____

Pref Lang.: □Eng □Other_____ **Race**: □White □AA □Hisp. □Asian □Native Am. □Other_____ **Ethnicity**: □Non-Hisp. □Hispanic

E-MAIL: You will receive emails for your EHR portal, yearly recalls, eye care news, and special promotions. You may opt out at any time.

Vision Insurance: □ None □ Davis □ Eyemed □ Spectera □ Tricare □ VSP □ Other_____

Medical Insurance: □ Aetna □ Blue Cross □ Blue Shield □ Cigna □ Medicare □ Tricare □ United Health □ Other_____

Member_____**Relation**_____ **DOB** ____/_____/_____ **ID / SSN** _____

Member_____**Relation**_____ **DOB** ____/_____/_____ **ID / SSN** _____

FAMILY MEMBERS

Name	Relation	DOB	Current patient at our office?
	/		YES / NO
	/		YES / NO
	/		YES / NO
	/		YES / NO

Payments and Co-Payments All required payments, co-payments, deductibles, and other out-of-pocket expenses are due in full at the time services are rendered or materials are provided, unless specific financial agreements have been made prior to your scheduled appointment. The office accepts VISA, Master Card, debit cards and personal checks with proper identification. All personal checks returned for any reason are subject to a $25 service charge without exception. In the event of nonpayment, the cost of collection and or court costs and reasonable legal fees is the responsibility of the patient.

Vision Plan and Insurance Benefits It is your responsibility to understand the nature of your vision plan and insurance benefits prior to your scheduled appointment. The employees of WERNER OPTOMETRY will, to the best of their knowledge and understanding, help answer any questions you may have regarding your vision plan and insurance benefits; however, no guarantee of accuracy regarding eligibility, coverage, or benefit information can be made by anyone other than your vision plan or insurance carrier directly.

Assignment of Benefits I authorize assignment of vision plan and insurance benefits to WERNER OPTOMETRY for the purpose of determining eligibility, benefits, and collecting for all services rendered and materials provided. In addition, I authorize WERNER OPTOMETRY and any of its employees to furnish information concerning my present condition to insurance companies and referring doctors as deemed necessary.

Missed, Broken & Cancelled Appointments If a scheduled appointment time is missed, broken, or cancelled for any reason without 48 hours notice, a fee of $35 may be assessed to your account. Please notify the office at least 48 hours in advance if you are unable to keep your appointment.

HIPPA Compliancy I acknowledge that I have received a copy of the Notice of Privacy Practices (HIPPA) for this office. I have read and understood the terms and conditions outlined above, and I hereby certify that all of the information provided is true and accurate to the best of my knowledge and understanding.

Signature:_____**Date:**_____