

1. PATIENT INFORMATION:

Name _____ Birthdate _____
Mailing address _____ City _____ ZIP _____
Home Phone _____ E-mail address _____ Marital status _____ Sex _____
Occupation _____ Employer _____ Wk.Phone _____
Name of spouse _____ Spouse's employer _____ Phone _____
Do you have any children living at home? Yes No
If patient is a child, please give parent's/guardians names _____
In case of emergency, whom would you like contacted? _____ Ph# _____
How did you learn about our office? Phone Book Insurance List Website I was walking by
 Other _____ Family/Friend Name of the person referring you? _____

2. INSURANCE INFORMATION:

Primary insurance _____ Address _____
ID# _____ Group# _____ Effective date _____
Subscriber's name _____ DOB _____ Employer _____
Secondary insurance _____ ID# _____

(Please provide proof of insurance and any necessary forms. Without verification from insurance company you will be asked to pay for services in full.)

3. I UNDERSTAND THAT I AM RESPONSIBLE TO PAY LAYNE R. CHRISTENSEN, O.D., INC., FOR ANY AMOUNT NOT PAID FOR BY MY INSURANCE OR NOT INCLUDED OR APPROVED BY MY MANAGED CARE INSURANCE PROGRAM. I HEREBY ASSIGN, TRANSFER, AND SET OVER ALL INFORMATION NECESSARY TO SECURE PAYMENTS AND IF MY MEDICAL INSURANCE IS BILLED FOR ME OR MY DEPENDENTS, I AUTHORIZE PAYMENT OF THOSE BENEFITS TO BE PAID DIRECTLY TO THE DOCTOR. THIS AUTHORIZATION SHALL REMAIN VALID UNTIL WRITTEN NOTICE IS GIVEN BY ME REVOKING SAID AUTHORIZATION. **PROFESSIONAL FEES ARE DUE AT THE TIME THE SERVICES ARE RENDERED. GLASSES, CONTACT LENSES, AND SUPPLIES MUST BE PAID FOR WHEN ORDERED.** A \$5.00 BILLING CHARGE WILL BE APPLIED TO ANY OUTSTANDING BALANCE AND WILL ACCRUE MONTHLY.

Signed _____ Relationship to patient _____

4. Acknowledgment of receipt of Medical Records Confidentiality Policy:

I have received and read a copy of Layne R. Christensen, O.D.'s policy regarding Medical Records Confidentiality. I do hereby acknowledge that I am familiar with and fully understand the terms and conditions of the consent.

Signed _____ Date _____

5. If patient is under 18 years of age, I authorize treatment:

Signed _____ Relationship to patient _____ Phone _____