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? ☐ Family/Friend - Name of the person referring you? ______________

☐ Phone Book ☐ Insurance List ☐ Website ☐ Social Media ☐ I was walking by ☐ Other ___________

2. INSURANCE INFORMATION:

If you have Vision Service Plan (**VSP**) we need the last four digits of your SS# ____________

Primary insurance__________________ 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___________________________

**Please list those that you give permission for us to share medical and/or financial information with:

Name:________________________ Relationship:__________________ Phone Number:_______________

Name:________________________ Relationship:__________________ Phone Number:_______________

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

Signed_________________________________Relationship to patient_______________Phone__________