**1.** **PATIENT INFORMATION:**

Name Birthdate / / Sex: M/F Marital status

Mailing address City ZIP Home Phone

E-mail address Would you like messages by text? Y/N Cell Phone Occupation Employer Work Phone

Name of spouse Spouse’s employer 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? 🞏 I was walking by 🞏 Social Media 🞏 Our Website 🞏 Insurance List 🞏 Phone Book 🞏 Other

**2.** **INSURANCE INFORMATION**:

If you have Vision Service Plan (**VSP**) we need the last four digits of the member or insured 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\_\_\_\_\_\_\_\_\_\_

Welcome 2015/02/12