1. PATIENT INFORMATION:

Name_______________________________________Birthdate______/_____/________ Sex: M/F Marital status_________

Mailing address____City________________ZIP____________

Home Phone_____________________________ E-mail address____

Cell Phone_______________________________ **Would you like messages by text? Y/N**

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___________