# MUD SPRINGS VISION CLINIC

## PATIENT INFORMATION

**Name** _____ **SSN** _____ - _____ - _____

**Gender** ☐ **M** ☐ **F** **Age** _____ **Date of Birth** _____ (MM DD YYYY) ☐ **Minor** ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**

**Race** _____ **Ethnicity** _____

**Street Address** _____ **City** _____ **State** _____ **Zip** _____

**Mailing Address** *(if different)* _____ **City** _____ **State** _____ **Zip** _____

**Home Phone** _____ **Cell Phone*** _____ **Email** _____

**I consent for Mud Springs Vision Clinic to call using my cell phone number and to leave a message regarding appointments, treatment, insurance, and my account. I may withdraw consent at any time.* _____ (Initial)

**Employer** _____ **Work Phone** _____

**Spouse's Name** _____ **Spouse's Employer** _____

**Is this appointment the result of an auto or other accident?** ☐ **Yes** ☐ **No**

## INSURANCE INFORMATION

***PRIMARY VISION INSURANCE*** ☐ **None**

**Patient's Relationship to Insured:** ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

**Insurance Plan Name** _____ **ID#** _____ **Group#** _____

**Insurance Plan Address** _____ **Phone Number** _____

***COMPLETE IF DIFFERENT FROM PATIENT INFORMATION:***

**Insured's Name** _____ (LAST FIRST M) **Insured's Date of Birth** _____ (MM DD YYYY) **SSN** _____ - _____ - _____

**Insured's Address** _____ **City** _____ **State** _____ **Zip** _____

**Insured's Employer** _____ **Address** _____ **City** _____ **State** _____ **Zip** _____

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***MEDICAL INSURANCE*** ☐ **None**

**Patient's Relationship to Insured:** ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

**Insurance Plan Name** _____ **ID#** _____ **Group#** _____

**Insurance Plan Address** _____ **Phone Number** _____

***COMPLETE IF DIFFERENT FROM PATIENT INFORMATION:***

**Insured's Name** _____ (LAST FIRST M) **Insured's Date of Birth** _____ (MM DD YYYY) **SSN** _____ - _____ - _____

**Insured's Address** _____ **City** _____ **State** _____ **Zip** _____

**Insured's Employer** _____ **Address** _____ **City** _____ **State** _____ **Zip** _____

**Signature of Patient or Responsible Party** _____ **Date** _____

## FINANCIAL POLICY

**Fees must be paid in full at time of treatment. If Insurance applies: Although this office files insurance claims as a service to the patient, the insurance contract is between the patient and the insurance company. As we have no control over the insurance company's method of payment or amount of payment, any difference of payment is entirely the responsibility of the patient. INITIALS:** _____

## HIPPA ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**PLEASE PRINT NAME:** _____ **SIGNATURE:** _____ **DATE:** _____

*****You may refuse to sign this acknowledgment***

**FOR INTERNAL USE ONLY**

☐ Patient refused to sign HIPPA _____ Employee Signature