WALLINGFORD EYE CARE - OFFICE OF DR. SUSAN ROH

WELCOME TO OUR OFFICE

Please complete the following information

OCIAL SECURITY NUMBER DATE OF BIRTH SEX M / F SINGLE / MARRIED / OTHER STATE ZIP CODE TOME ADDRESS CITY STATE ZIP CODE TOME PHONE WORK OR CELL PHONE EMAIL ADDRESS MPLOYER (SCHOOL) OCCUPATION (GRADE) HOBBIES DINURANCE DINURANCE INTERNET DIOCATION WORK REFERRED BY: FRIEND DIOCATION WHOM MAY WE THANK FOR REFERRING YOU? MERGENCY CONTACT MERGENCY CONTACT MERGENCY CONTACT NAME HOME PHONE CELL PHONE RELATION TO PATIENT TISION INSURANCE COVERAGE AME OF PARENT / GUARDIAN HOME PHONE CELL PHONE RELATION TO PATIENT RELATION TO	PATIENT IDENTIFYING IN								
IOME ADDRESS CITY STATE ZIP CODE OME PHONE WORK OR CELL PHONE EMAIL ADDRESS MPLOYER (SCHOOL) OCCUPATION (GRADE) HOBBIES HOW DID YOU HEAR ABOUT OUR OFFICE INSURANCE INSURANCE INSURANCE INSURANCE INSURANCE INSURANCE INSURANCE INSURANCE TEREND INSURANCE CELL PHONE RELATION TO PATIENT F PATIENT IS UNDER 18 YEARS OF AGE AMBE OF PARENT / GUARDIAN HOME PHONE CELL PHONE RELATION TO PATIENT INSURANCE COVERAGE AMBE OF VISION INSURANCE CO. POLICY HOLDER (EMPLOYEE) POLICY HOLDER BIRTH DATE RELATION TO PATIENT ROUP NAME GROUP NUMBER INSURANCE CO. PHONE # RELATION TO PATIENT ROUP NAME GROUP NUMBER INSURANCE CO. PHONE # RELATION TO PATIENT ROUP NAME RELATION TO PATIENT RELATION TO PATIE	LAST NAME				FIRST NAME			LE	
IOME ADDRESS CITY STATE ZIP CODE WORK OR CELL PHONE EMAIL ADDRESS MPLOYER (SCHOOL) OCCUPATION (GRADE) HOBBIES HOW DID YOU HEAR ABOUT OUR OFFICE JINSURANCE MERGENCY CONTACT MERGENCY CONTA	SOCIAL SECURITY NUMBER		DATE OF BIRTH	SEX	(MARITAL STATUS	l l		
MPLOYER (SCHOOL) OCCUPATION (GRADE) HOBBIES HOW DID YOU HEAR ABOUT OUR OFFICE JINNIRANCE INTERNET REFERRED BY: WHOM MAY WE THANK FOR REFERRING YOU? MERGENCY CONTACT MERGENCY CONTACT MARE HOME PHONE CELL PHONE RELATION TO PATIENT F PATIENT IS UNDER 18 YEARS OF AGE AME OF PARENT / GUARDIAN HOME PHONE CELL PHONE RELATION TO PATIENT //SION INSURANCE COVERAGE AME OF VISION INSURANCE CO. POLICY HOLDER (EMPLOYEE) POLICY HOLDER BIRTH DATE RELATION TO PATIENT MEDICAL INSURANCE COVERAGE AME OF MEDICAL INSURANCE CO. POLICY HOLDER (EMPLOYEE) POLICY HOLDER BIRTH DATE RELATION TO PATIENT MEDICAL INSURANCE COVERAGE AME OF MEDICAL INSURANCE CO. POLICY HOLDER (EMPLOYEE) POLICY HOLDER BIRTH DATE RELATION TO PATIENT MEDICAL INSURANCE COVERAGE AME OF MEDICAL INSURANCE CO. POLICY HOLDER (EMPLOYEE) POLICY HOLDER BIRTH DATE RELATION TO PATIENT MEDICAL COVERAGE INSURANCE CO. POLICY HOLDER (EMPLOYEE) POLICY HOLDER BIRTH DATE RELATION TO PATIENT THE PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF PAYAL BLIL AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. DITHORIZE MY INSURANCE CLAIM TO BE PAID DIRECTLY TO THE CLINIC. GNATURE OF RESPONSIBLE PARTY					M / F SINGLE / MARRIEI			D / OTHER	
MPLOYER (SCHOOL) OCCUPATION (GRADE) HOBBIES HOW DID YOU HEAR ABOUT OUR OFFICE	HOME ADDRESS			CIT	Y		STATE	ZIP CODE	
MPLOYER (SCHOOL) OCCUPATION (GRADE) HOBBIES HOW DID YOU HEAR ABOUT OUR OFFICE									
HOW DID YOU HEAR ABOUT OUR OFFICE INSURANCE	IOME PHONE	E PHONE WORK OR CELL PHONE			EMAIL ADDRESS				
INSURANCE INTERNET FRIEND DOCTOR WHOM MAY WE THANK FOR REFERRING YOU? MERGENCY CONTACT MERGENCY CONTACT HOME PHONE CELL PHONE RELATION TO PATIENT	EMPLOYER (SCHOOL) OCCUPATION (GRADE)			НО	HOBBIES				
INSURANCE INTERNET FRIEND DOCTOR WHOM MAY WE THANK FOR REFERRING YOU? MERGENCY CONTACT MERGENCY CONTACT HOME PHONE CELL PHONE RELATION TO PATIENT	, , ,		, ,						
INTERNET INTERN	HOW DID YOU HEAR AB								
MERGENCY CONTACT MERGENCY CONTACT MERGENCY CONTACT NAME HOME PHONE CELL PHONE RELATION TO PATIENT F PATIENT IS UNDER 18 YEARS OF AGE AME OF PARENT / GUARDIAN HOME PHONE CELL PHONE RELATION TO PATIENT RELATION TO PATIENT POLICY HOLDER BIRTH DATE RELATION TO PATIENT REL	☐ INSURANCE ☐ INTERNET	I INSURANCE INTERNET REFERRED BY:			WHOM MAY WE THANK FOR REFERRING YOU?				
F PATIENT IS UNDER 18 YEARS OF AGE IAME OF PARENT / GUARDIAN HOME PHONE CELL PHONE RELATION TO PATIENT INSURANCE COVERAGE IAME OF VISION INSURANCE CO. POLICY HOLDER (EMPLOYEE) POLICY HOLDER BIRTH DATE RELATION TO PATIENT INSURANCE COVERAGE IAME OF MEDICAL INSURANCE COVERAGE IAME OF MEDICAL INSURANCE COVERAGE IAME OF MEDICAL INSURANCE CO. POLICY HOLDER (EMPLOYEE) POLICY HOLDER BIRTH DATE RELATION TO PATIENT IROUP NAME GROUP NUMBER INSURANCE CO. POLICY HOLDER (EMPLOYEE) POLICY HOLDER BIRTH DATE RELATION TO PATIENT INSURED ID NUMBER INSURANCE CO. PHONE # THE PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF POLICY HOLDER TO PAY ALL BILL AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. ITHORIZE PHYSICIAN AND CLINIC TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I ALITHORIZE MY INSURANCE CLAIM TO BE PAID DIRECTLY TO THE CLINIC. GNATURE OF RESPONSIBLE PARTY DATE DATE	□ LOCATION □ WORK		FRIEND DOCTOR						
F PATIENT IS UNDER 18 YEARS OF AGE TAME OF PARENT / GUARDIAN HOME PHONE CELL PHONE RELATION TO PATIENT FINANCE COVERAGE TAME OF VISION INSURANCE CO. POLICY HOLDER (EMPLOYEE) POLICY HOLDER BIRTH DATE RELATION TO PATIENT FROUP NAME GROUP NUMBER INSURED ID NUMBER INSURANCE CO. PHONE # MEDICAL INSURANCE COVERAGE TAME OF MEDICAL INSURANCE CO. POLICY HOLDER (EMPLOYEE) POLICY HOLDER BIRTH DATE RELATION TO PATIENT FROUP NAME GROUP NUMBER INSURED ID NUMBER INSURANCE CO. PHONE # THE PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MOVELEDGE. I ACCEPT RESPONSIBILITY FOR THE VISION AND MEDICAL CHARGES INCURRED BY THE PATIENT DATE IN THE PATIENT OF PAY ALL BILL AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. ITHORIZE PHYSICIAN AND CLINIC TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I ALL ITHORIZE MY INSURANCE CLAIM TO BE PAID DIRECTLY TO THE CLINIC. GNATURE OF RESPONSIBLE PARTY	EMERGENCY CONTACT								
AME OF PARENT / GUARDIAN HOME PHONE CELL PHONE RELATION TO PATIENT //SION INSURANCE COVERAGE AME OF VISION INSURANCE CO. POLICY HOLDER (EMPLOYEE) POLICY HOLDER BIRTH DATE RELATION TO PATIENT PROUP NAME GROUP NUMBER INSURED ID NUMBER INSURANCE CO. PHONE # POLICY HOLDER BIRTH DATE RELATION TO PATIENT	MERGENCY CONTACT NAME HOME PHONE		OME PHONE	CEI	CELL PHONE		RELATION TO PATIENT		
AME OF VISION INSURANCE COVERAGE TAME OF VISION INSURANCE CO. POLICY HOLDER (EMPLOYEE) POLICY HOLDER BIRTH DATE RELATION TO PATIENT RELATION TO PATIENT	IF PATIENT IS UNDER 18 Y	EARS	OF AGE						
RAME OF VISION INSURANCE CO. POLICY HOLDER (EMPLOYEE) POLICY HOLDER BIRTH DATE RELATION TO PATIENT RELATION TO PATIENT RECOUP NAME GROUP NUMBER INSURED ID NUMBER INSURANCE CO. PHONE # MEDICAL INSURANCE COVERAGE LAME OF MEDICAL INSURANCE CO. POLICY HOLDER (EMPLOYEE) POLICY HOLDER BIRTH DATE RELATION TO PATIENT	NAME OF PARENT / GUARDIAN	HOME PHONE		CEI	CELL PHONE		RELATION TO PATIENT		
GROUP NAME GROUP NUMBER INSURED ID NUMBER INSURANCE CO. PHONE# MEDICAL INSURANCE COVERAGE AME OF MEDICAL INSURANCE CO. POLICY HOLDER (EMPLOYEE) POLICY HOLDER BIRTH DATE RELATION TO PATIENT GROUP NAME GROUP NUMBER INSURED ID NUMBER INSURANCE CO. PHONE# THE PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF PROPERTY OF A CONTROL OF THE VISION AND MEDICAL CHARGES INCURRED BY THE PATIENT OF A CONTROL OF THE VISION AND MEDICAL CHARGES INCURRED BY THE PATIENT OF A CONTROL OF THE VISION AND MEDICAL CHARGES INCURRED BY THE PATIENT OF THE VISION AND MEDICAL CHARGES INCURRED BY THE PATIENT OF THE VISION AND MEDICAL CHARGES INSURANCE CLAIMS. I ALITHORIZE PHYSICIAN AND CLINIC TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I ALITHORIZE MY INSURANCE CLAIM TO BE PAID DIRECTLY TO THE CLINIC. GNATURE OF RESPONSIBLE PARTY DATE DATE	VISION INSURANCE COV	ERAGI	E						
MEDICAL INSURANCE COVERAGE IAME OF MEDICAL INSURANCE CO. POLICY HOLDER (EMPLOYEE) POLICY HOLDER BIRTH DATE RELATION TO PATIENT RELATION TO PATIENT THE PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MATE TO WLEDGE. I ACCEPT RESPONSIBILITY FOR THE VISION AND MEDICAL CHARGES INCURRED BY THE PATIENT TO AGREE TO PAY ALL BILL AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. TO THORIZE PHYSICIAN AND CLINIC TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I ALL TO THE CLINIC. TO THE CLINIC. DATE DATE	NAME OF VISION INSURANCE CO.	PO	POLICY HOLDER (EMPLOYEE)		POLICY HOLDER BIRTH DATE		E RELATION TO PATIENT		
THE PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MINIOR OF PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MINIOR OF PATIENT OR PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MINIOR OF PATIENT OR ACCEPT RESPONSIBILITY FOR THE VISION AND MEDICAL CHARGES INCURRED BY THE PATIENT OF PATIEN	GROUP NAME	Gl	GROUP NUMBER		INSURED ID NUMBER		INSURANCE CO. PHONE #		
THE PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MINIOR OF PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MINIOR OF PATIENT OR PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MINIOR OF PATIENT OR ACCEPT RESPONSIBILITY FOR THE VISION AND MEDICAL CHARGES INCURRED BY THE PATIENT OF PATIEN	MEDICAL INCIDANCE CO	WED A	CE						
GROUP NUMBER INSURED ID NUMBER INSURED ID NUMBER INSURANCE CO. PHONE # THE PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF M IOWLEDGE. I ACCEPT RESPONSIBILITY FOR THE VISION AND MEDICAL CHARGES INCURRED BY THE PATIENT ID AGREE TO PAY ALL BILL AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. ITHORIZE PHYSICIAN AND CLINIC TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I ALITHORIZE MY INSURANCE CLAIM TO BE PAID DIRECTLY TO THE CLINIC. GNATURE OF RESPONSIBLE PARTY				EE/	POLIC	A HUI DEB BIBTH DV	re i	DELATION TO PATIENT	
THE PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF A TOWLEDGE. I ACCEPT RESPONSIBILITY FOR THE VISION AND MEDICAL CHARGES INCURRED BY THE PATIENT OF AGREE TO PAY ALL BILL AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. ITHORIZE PHYSICIAN AND CLINIC TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I ALITHORIZE MY INSURANCE CLAIM TO BE PAID DIRECTLY TO THE CLINIC. GNATURE OF RESPONSIBLE PARTY	NAME OF MEDICAL INSURANCE CO.		POLICY HOLDER (EMPLOYEE)		TOLICI HOLDER BIRTH DATE			RELATION TO TABLE	
IOWLEDGE. I ACCEPT RESPONSIBILITY FOR THE VISION AND MEDICAL CHARGES INCURRED BY THE PATIEI ID AGREE TO PAY ALL BILL AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. ITHORIZE PHYSICIAN AND CLINIC TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I ALITHORIZE MY INSURANCE CLAIM TO BE PAID DIRECTLY TO THE CLINIC. GNATURE OF RESPONSIBLE PARTY	GROUP NAME	Gl	ROUP NUMBER		INSURED ID NUMBER		1	INSURANCE CO. PHONE #	
IOWLEDGE. I ACCEPT RESPONSIBILITY FOR THE VISION AND MEDICAL CHARGES INCURRED BY THE PATIEI ID AGREE TO PAY ALL BILL AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. ITHORIZE PHYSICIAN AND CLINIC TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I ALITHORIZE MY INSURANCE CLAIM TO BE PAID DIRECTLY TO THE CLINIC. GNATURE OF RESPONSIBLE PARTY	THE PATIENT OF CHARAN	TOR (CEDTIEV THAT THE		MATIO	N ON THIS EOR	M IS TRI	IE TO THE BEST OF A	
	IOWLEDGE. I ACCEPT RE ID AGREE TO PAY ALL ITHORIZE PHYSICIAN ANE	SPONS BILL A CLIN	IBILITY FOR THE V T THE TIME OF IC TO RELEASE AN	'ISION A SERVIC IY INFO	ND MI E UNL Rmati	EDICAL CHARG ESS OTHER AF ON TO PROCES	ES INCU Rrangei	RRED BY THE PATIEN MENTS ARE MADE.	
	GNATURE OF RESPONSIB	SLE PA	RTY				D.	ATE	
			-						

Date:

WALLINGFORD EYE CARE – OFFICE OF DR. SUSAN ROH

FINANCIAL POLICY

- 1. **NO INSURANCE COVERAGE**: Payment for all services provided is expected at the time services are rendered. All materials (eyeglasses, contacts, etc.) must be paid for in full before they can be taken from the office. <u>Eyeglass lenses are custom made and cannot be refunded.</u>
- 2. **INSURANCE COVERAGE**: As a courtesy, we will contact your insurance company for benefit eligibility and coverage. However, cost quotations from the insurance company are not a guarantee of payment. Health insurance is a personal contract between you and your insurance company, thus you are responsible for knowing the limitations of your insurance contract as well as your eligibility for coverage. Should your insurance deny your claim or eligibility for coverage, you are responsible for all fees accrued in your behalf.
- 3. **ACCOUNTS WITH OUTSTANDING BALANCE:** Bills must be paid within 30 days from receipt of statement, unless other arrangements are made; if full payment has not been received within 30 days, the account will be past due and a 12% finance charge will be added to the balance. Returned checks are subject to a \$50.00 processing fee.
- 4. **INITIATION OF COLLECTION PROCEEDINGS:** All accounts that are 90 days past due will be referred for collection proceedings. In the event collection proceedings are initiated, you will be responsible for any interest accrued on the balance and all billing fees, i.e., collection cost, attorney fees, court costs, etc.

I have read, understand and agree to follow the Financial Policy of Wallingford Eye Care. I understand that I am ultimately responsible for payment of the account. I authorize payment of insurance benefits to this office. I also authorize release of any medical records necessary to process any insurance claims.

SIGNATURE OF RESPONSIBLE PARTY ______ DATE _____

HIPAA PRIVACY POLICY
Your medical records are confidential and we make every effort to preserve that confidentiality. I understand that by signing this consent form, I am allowing my medical information to be released to requesting physicians and insurance companies for the purpose of health care operations (including but not limited to provider reviews, claims payment, and quality assessment). I understand that I may revoke this consent by written request at any time. If revoked it is understood by all parties that all information released prior to being notified of such revocation was made by consent.
The uses and disclosures of protected health information for marketing purposes, disclosures that constitute a sale of protected health information, and other uses and disclosures not described in this policy require my authorization.
I have the right to restrict certain disclosures of protected health information to a health plan if I pay out of pocket in full for health care item or service.
In the event there is a breach of my unsecured protected health information, I have the right to receive notification of such breach.
I understand that I have the right to restrict disclosure of specific information in my medical records if I request such restriction in writing. I understand that my request for restriction may be denied if the information restricted is required for health care operations.
I have read the above and foregoing consent for release of information and acknowledge and understand the terms and conditions of the consent.
SIGNATURE OF RESPONSIBLE PARTY DATE
OPTIONAL:
I give permission to the following individual(s) to have access to my confidential medical information:
Name:Phone #:Phone #:
Name: Relationship to Patient: Phone #:

12/13