WELCOME TO MAISON OPTIQUE OPTOMETRIC CENTER

Please fill out the form for billing and insurance purposes:

Prefix (Circle One): Mr. Miss. Ms. Mrs. Dr. Rev.

Last:_____ **First:**_____**MI**:_____**Suffix:**_____

Nickname: _____

Patient's SSN:_____-_____-_____**Driver's License#:**_____ **DOB**:_____

Sex (Circle One): Male Female **Marital Status (Circle One):** Single Married Divorced Widowed Other

Address:_____**City:**_____**State:**_____**Zip:**_____

Home Phone: (___)_____**Cell Phone:** (___)_____**Work Phone:** (___)_____

E-mail Address:_____

Employer (or school):_____ **Occupation (or grade)**:_____

Emergency Contact:_____ **Phone:** (___)_____

Relationship to patient:_____ **(i.e. Spouse, Parent, Guardian, etc.)**

The HIPAA Privacy Rule:

By signing this you acknowledge the access to the notice of HIPAA. The notice provides information about how we may use and disclose your protected optical and medical health information. We encouraged you to read in full. Copies are available in the office.

Patient Signature Required:_____**Date:**_____

Who may we thank for referring you to our office? Name of friend or relative _____

INSURANCE INFORMATION	
Vision Insurance _____	Medical Insurance _____
Subscriber Name _____	Subscriber Name _____
Member I.D.# (if any) _____	Member I.D. # (if any) _____
Group # (if any) _____	Group # (if any) _____
Subscriber SSN _____	Subscriber SSN _____
Subscriber DOB _____	Subscriber DOB _____

THE FOLLOWING STATEMENTS MUST BE REVIEWED BY THE PERSON RESPONSIBLE FOR PAYMENT:

- I understand that I am responsible for all charges/fees not covered by my insurance plan.
- I acknowledge that full payment for procedures not covered by my insurance is required at the time of service.
- I authorize payment of medical or vision benefits to Robert Tamayo, O.D. and/or Linh Tu, O.D., for any eligible services I receive at this office.
- I authorize the doctor and staff to administer such treatments as reasonable or necessary in connection with the condition for which I, or members of my family have sought care for, to the extent necessary to determine liability of payments and to obtain reimbursement or process any claims (insurance or otherwise)
- I authorize the doctor's office to release any portion of my medical records or other information to any person, organization or agency that is or may be liable for any portion of the office charge.

If patient will be fit for contact lenses:

- I understand that the contact lens fitting fee is a non-refundable service charge whether the fit is successful or not.
- I understand that the contact lens fitting fee includes all contact lens follow-up visits performed within 3 months of the initial contact lens fitting.
- I understand that the prescribing doctor will release my contact lens prescription once I have returned for all necessary follow-up appointments. The contact lens prescription will be valid for one year from the date of the original exam.
- I understand that the contact lens fitting fee does not include services provided to treat eye infections, abrasions, trauma or any other medical conditions incurred while using contact lenses whether they can be attributed to actual contact lens use or not. Treatment of these medical conditions will be billed to my medical insurance when applicable. If I do not have any medical insurance, I will be responsible for the charges incurred.
- *There will be a **$25.00** service fee for all Returned, Non-sufficient Funds, or illegally written checks.*

_____ _____

Signature* (If patient is under 18, parent or legal guardian must sign)** ***Date