

Seattle Ophthalmology, PLLC

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Tel 206.328.7614 ♦ Fax 206.328.6280

PATIENT INFORMATION

Date: _____

Title: Dr. Mr. Mrs. Ms. Patient Name: _____

Sex: Male Female Marital Status: Single Married Widowed Other

Date of Birth: ____/____/____ Social Security Number: ____-____-____

Parent / Guardian (if patient is a minor), Name & Contact: _____

Patient Address: _____
Street City State Zip

Billing Address (if different): _____

Home Phone: (____)____-____ Work Phone: (____)____-____

Cell Phone: (____)____-____ E-mail (optional): _____

Employer: _____ Occupation: _____

Spouse's (or Significant Other's) Name: _____

Referred by: _____

Primary Care Physician: _____ Phone: (____)____-____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone (____)____-____

INSURANCE INFORMATION – *We must have a copy of your insurance card(s) at each visit in order to bill your insurance company(ies).*

Insurance Company: _____	Effective Date: _____	
ID # _____	Group # _____	Co-Pay \$ _____
Is the patient the subscriber? Yes No If no, complete the following Subscriber Information:		
Name _____	Date of Birth ____/____/____	Patient's Relationship: _____

Insurance Company: _____	Effective Date: _____	
ID # _____	Group # _____	Co-Pay \$ _____
Is the patient the subscriber? Yes No If no, complete the following Subscriber Information:		
Name _____	Date of Birth ____/____/____	Patient's Relationship: _____

Please Turn Over

Appointment Policies

We request all cancellations and appointment changes to be made 24 hours in advance of scheduled appointments. This allows other patients the opportunity to use the available time. If you continually fail to show for scheduled appointments without calling ahead, a fee may be assessed and treatment discontinued.

We value your time and do not wish to keep you waiting. However, on occasion, an unexpected event may occur. If you are delayed well past your scheduled appointment time, we will make every effort to meet your needs, but your appointment may need to be rescheduled. We appreciate your understanding.

Prescription Refill Policy

Please allow 2 business days for completing prescription refill requests. Please note that all non-emergent refill requests that come in after hours or on the weekend will not be processed until the next business day.

Financial Policy

As a courtesy, we will bill your insurance company if we are provided with accurate, complete, and current insurance information. Although we make every effort to assist you with general insurance questions, specific questions regarding benefits and eligibility need to be directed to your insurance company. It is your responsibility to know your insurance requirements and benefits. This includes initiating the referral process with primary care physician, if required by your insurance plan. Co-pays are due at the time of service. A charge may be incurred if co-payment is not collected at time of office visit.

Please be aware that refractions (test to determine your glasses prescription) are never covered by Medicare and policy of payment varies between other insurance companies. Please contact your insurance company to see if this will be covered. Alert the technician at your appointment if you do not wish to have a refraction done at your appointment.

If you do not have insurance, we require payment at time of service; unless prior arrangements have been made. Payments may currently be made by Visa, MasterCard, Discover, American Express, cash or check.

If your personal check is returned by the bank due to *Insufficient Funds*, a fee will be charged. If you have financial problems, please communicate them as soon as possible so that we may work out a mutually beneficial payment plan to prevent your credit from being jeopardized.

Patient Consent and Release

I hereby consent to treatment by Seattle Ophthalmology. I understand that I am financially responsible for all charges rendered regardless of insurance reimbursement. I authorize Seattle Ophthalmology to release any necessary information requested by my insurance carrier and authorize payment directly to Seattle Ophthalmology for any benefits available under my insurance plan. I will advise the receptionist if any address, employment, or insurance changes have occurred since my last visit.

Notice of Information Practices

We keep a record of the services we provide you. You have a right to know how we use and disclose information about you. Your signature below serves as an acknowledgement that you have read and understand this form, as well as, the *Statement of Privacy Practices*.

Patient Signature _____ Date _____
(or legally authorized individual's signature)

Printed Name _____ Relationship to patient _____
(if signed on behalf of the patient)