Kennedy
Vision Health Center

Date ____/____/____

General Information:

Last Name: ______________ First Name: ______________ Middle: ________

Address: ______________________ City: ______________ State: _____ Zip: ______

Sex: ☐ Male ☐ Female Social Security #: ______/______/______ DOB: ____/____/____ Age: ______

Home Phone: (_____) ____________ Work Phone: (_____) ____________ Cell Phone: (_____) ____________

Email Address: ______________________

Emergency Contact Name: ______________ Relation: ____________ Phone #: (____) ____________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ______________________

<u>POLICYHOLDER</u> of insurance - (If different from above):

Last Name: ______________ First Name: ______________ Middle: ________

Address: ______________________ City: ______________ State: _____ Zip: ______

Social Security #: ______/______/______ DOB: ____/____/____

Home Phone: (_____) ____________ Work Phone: (_____) ____________ Cell Phone: (_____) ____________

VISION AND MEDICAL INSURANCE INFORMATION:

Do you have VSP (Vision Service Plan)? ☐ Yes ☐ No Policy Holder? ______________________

Name of Primary Medical Insurance Company: ______________________

ID Number: ______________ Group Number: ______________

Name of Secondary Medical Insurance Company: ______________________

ID Number: ______________ Group Number: ______________

I, undersigned have insurance coverage with the above named insurance carrier or carriers and assign directly to Kennedy Vision Center, LLC all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Note as a courtesy, we will submit your claim forms for you. Payments made by your insurance company will be immediately credited to your account. The remaining balance is due at the time of your next statement. We will prepare reports, other paperwork and follow through as needed for a nominal fee to the party requesting additional information. Most insurance companies process claim within 45 days or approximately 6 weeks. If your claim has not been processed by them, <u>payment from you is expected for the total amount of the claim submitted.</u> Form must be signed to authorize claim filing.

I acknowledge that I have been given access to / received a copy of Kennedy Vision Health Center's HIPPA notice of privacy practices.

Authorized Signature: ______________________ Date: ______________

☐ Patient Reviewed Date: __________ ☐ Patient Reviewed Date: __________ ☐ Patient Reviewed Date: __________