Welcome To Shawnee/Tecumseh Vision Source

Kyle Karnish, O.D. **Travis Kliewer, O.D.**
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Brianna Weber, O.D.

Please Fill In All Information

Legal Name: _____ **Sex:** (circle one) M F
(First) (MI) (Last) **DOB**: ____/_____/_____ **Age**: _____
Preferred Name:_____ **Social Security Number**: _____ - _____ - _____
Address: _____ **Marital Status**: (**circle one**) Married Single Divorced Widow
City, State, Zip: _____ **Employment Status**: (**circle one**) Part-Time / Full-Time Student
Home Phone: _____ Part –Time / Full –Time Employed Unemployed Retired
Cell Phone: _____**Text Ok**: Yes or No **Employer**:_____
Work Phone_____EXT._____ **Occupation**: _____
Email Address: _____
Primary Care Physician (Name/Location/Telephone)_____
How did you hear about us? Insurance_____ Saw Sign/Building_____ Yellow Pages _____ Internet Search _____ Billboard_____
Friends/Family_____ **Name of Person** (if you were referred):_____

PLEASE CIRCLE ALL THAT APPLY:

Race: (**circle one**) America Indian , Asian , African American , Hispanic , Native Hawaiian/Pacific Islander , Caucasian

Ethnicity: (**circle one**) Hispanic/Latino , Not Hispanic/Latino , Native Hawaiian/Pacific Islander

Communication Preference: (**circle one**) Home Phone Cell Phone Daytime Phone Email Text

Where was your last exam?_____**When was your last exam**? _____

Are you interested in? : Glasses (circle one) Yes or No **Contacts** (circle one) Yes or No **Lasik Vision Correction** (circle one) Yes or No

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In order to file any insurance claims, we must copy ALL insurance cards at the time of visit.

The following questions must be answered completely:

Attach all Insurance Cards (Medical and Vision) and Driver's License or Government Issued ID

Insurance Information- (MUST BE FILLED OUT COMPLETELY WITH PRIMARY CARDHOLDERS INFORMATION)

Vision Insurance

Primary Cardholder Name: _____ Insurance Name:_____
Primary Cardholder DOB: _____/_____/_____ Insurance ID #:_____
Primary Cardholder SSN: _____ - _____ - _____ Group #_____
Primary Cardholder Address: (if different from above)_____
Primary Cardholder Phone: (if different from above) Home: _____ Cell: _____
Primary Cardholder Employer: (if different from above)_____

Medical Insurance

Primary Cardholder Name: _____ Insurance Name:_____
Primary Cardholder DOB: _____/_____/_____ Insurance ID #:_____
Primary Cardholder SSN: _____ - _____ - _____ Group #_____
Primary Cardholder Address: (if different from above)_____
Primary Cardholder Phone: (if different from above) Home: _____ Cell: _____
Primary Cardholder Employer: (if different from above)_____

IF YOU HAVE A SECONDARY MEDICAL OR VISION INSURANCE PLEASE NOTIFY THE RECEPTIONIST !

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY

I acknowledge that I have been shown and read the "Notice of Privacy Practices" from Shawnee/Tecumseh Vision Source.

Would you like a copy of the Notice of Privacy Practice: (**circle one**) Yes No

Patient Name (please print)_____

Patient/Legal Guardian Name (Please Print): _____

Patient/Legal Guardian Signature:_____ **Date:**_____

Financial Responsibility: We will be happy to file your insurance claim forms or take assignment from your medical/vision benefits designated by the plan(s) of which you state the patient is a member. We will do all we can to help you receive maximum benefits. However, in the event that the plan sponsor determines that the patient is not eligible for coverage at the time of service., or makes a determination that the patient is eligible for a reduced level of coverage, by signing this statement you hereby agree to be financially responsible for any and all charges incurred by the patient and not paid by the plan sponsor at this and all future visits., payable at the time of service.

Collections: I understand and accept that if I have any unpaid balance with Shawnee/Tecumseh Vision Source (STVS) and do not bring my account current, my account can be placed with an external collection agency, and all costs and expenses including reasonable attorney's fees that SVS incurs in such collection efforts will be assessed to my account and include in the balance due. Finally, I understand that this will result in endangering my credit rating on a local and/or national level by being reported to all three credit bureau's (Equifax, TransUnion, Experian).

I authorize STVS to contact me via current and any future cellular phone number(s), email address(s), or wireless device(s) regarding my delinquent account(s), any other debit I owe to STVS or receive general information from STVS. I authorize STVS and its agents, representative, and attorneys (including collection agencies) to use automated telephone dialing equipment, artificial or pre-recorded voice or text messages, and personal calls and emails, in their effort to contact me for purposes of collecting any portion of my account financial obligations which is past due. Furthermore, I understand I may withdraw my consent to call my cellular phone by submitting my request in writing to STVS or its agents on behalf of STVS.

Patient Name (please print)_____

Patient/Legal Guardian Signature:_____

Relationship to Patient: _____ Date:_____

ALL PATIENTS UNDER 18YRS OLD MUST HAVE A GUARANTOR

Guarantor must be Legal Guardian (custody or guardianship papers must be provided if necessary)

Legal Guardian Full Name

(Please Print): (First) _____ (Middle Initial) _____ (Last)_____

Relationship to Patient: _____ **Phone:** _____

Legal Guardian Address: (if different from patient) _____

Legal Guardian Full SSN: _____ **Date of Birth:** _____

Legal Guardian Employer:_____ **Work Phone:**_____

Authorization of Release of Information

In order to safeguard patient information and comply with HIPAA standards we are unable to discuss any account issues or patient records unless notified in writing by the patient (if over the age of 18 yrs old) or patient legal guardian (if patient is under the age of 18 yrs old). This includes release of prescriptions or billing information.

I hereby authorize the release of my Medical Records from Shawnee/Tecumseh Vision Source to the following person:

Individual Name: _____ **Relationship to Patient:** _____

Date of Birth: _____ **Last 4 of individual SSN:**_____ **(used to verify identity of individuals calling into our office)**

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

Phone Number:_____ **Email:** _____

I understand that I have the right to revoke this request in writing at any time, except to the extent that action has already been taken to comply with it. Unless revoked, this authorization will remain valid indefinitely.

Patient/Legal Guardian Signature: _____