THIS FORM IS TO BE FILLED OUT IN FULL EVERY YEAR BY EVERY PATIENT

REFUSAL TO FILL OUT THIS FORM IN FULL WILL DENY YOU SERVICES

PATIENT NAME: _____DATE: _____/_____/_____
Address: _____ City: _____ State: _____ Zip: _____
Birth Date: ____/____/_____ Home Phone: _____ Cell Phone: _____
Social Security #: _____-____-_____ Email: _____
(If under 18 please provide social security # of responsible party) Work Phone: _____
Your or Your Parent's Employer: _____ Phone: _____
Other Employer: _____ Phone: _____
Spouse or Partners Name: _____ Phone: _____
Were you referred to us? ____ Yes ____ No If yes, by whom? _____
Whom may we contact in case of an emergency? _____ Phone: _____

PLEASE FILL IN YOUR INSURANCE INFORMATION BELOW:

Primary Insurance Company Name: _____
Policy Holder's Name: _____ Policy Number: _____
Relationship to Policy Holder: _____ Self _____ Spouse _____ Child _____ Other _____
Secondary Insurance Company Name: _____
Policy Holder's Name: _____ Policy Number: _____
Relationship to Policy Holder: _____ Self _____ Spouse _____ Child _____ Other _____

RESPONSIBLE PARTY

Whether I have Insurance of not, any and all fees incurred during my exam are ultimately my responsibility, or the responsibility of my legal guardian, and will be paid in full no later then 30 days after services have been rendered. I agree to pay these fees in full for the balance of my exam fees and glasses and/or contacts ordered with: Cash ____ Credit Card (Visa, Master Card) _____ Check _____

Signature: _____ Date: _____/_____/_____

SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct to the best of my knowledge. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits. I authorize payment of these benefits directly to Dr Jonathan C. Ashbaker, O.D. Of 8217 East Mill Plain Blvd, Vancouver, Wa. 98664 on my behalf for any and all services and materials furnished. I authorize any holder of medical information to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to the related services. If I have any other health insurance coverage (as indicated in item 9 of the HCFA_1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

Signature: _____ Date: _____/_____/_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

Signature: _____ Date: _____/_____/_____

OFFICE USE ONLY

On _____/_____/_____, an acknowledgement of Notice of Privacy Policies form was delivered. This form was not signed due to:____ communication barriers ____ an emergency ____ refusal to sign.