RooseveltVision

Patient Name: First_____ M.I. ___ Last_____

Address:_____**APT#**_____

City:_____**ST:**_____**Zip:**_____

Preferred Phone (C/H/W):_____ **DOB**:_____ **SSN**_____

Patient Sex (Required by insurance) M/F

Preferred Pronouns (Circle One): He/Him/His, She/Her/Hers, They/Them/Their, Mx

Email:_____

Employer: _____ **Occupation:**_____

Emergency Contact:_____ **Contact Phon**e:_____

Parent/ Guardian with patient:_____

Insurance Name:_____ **Insurance ID #:**_____

Subscriber Name:_____Subscriber Date of Birth:_____

Pharmacy:_____ **Family Doctor:**_____

Referred By: ( ) Patient_____ ( )Provider_____( )Other:_____

Race: ( )Caucasian ( )African American ( )Asian ( )Other_____

Ethnicity: ( )Non-Hispanic ( )Hispanic-Latino

Please Read: Payment for services is due at time services are rendered unless other arrangements have been made in advance. Most insurance policies pay only a portion of your total charges. **Ultimate responsibility for verifying insurance coverage and eligibility rests with the patient. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company** and that final determination can only be made when the claim is processed. Accounts 60 days old are subject to additional collection fees and interest charges of 1.5% per month. There will be a service charge on all returned checks. I understand (even if I do have insurance) that I will be financially responsible for payment of all charges incurred for services from this office. I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefit either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the physician or supplier for the services rendered. **I understand that a cancellation fee of $80 may be applied to all appointments missed or changed with less than 24 hours' notice.**

- **Signature** _____ Date: _____

Acknowledgement of Receipt of Privacy Policies: I acknowledge that I have received a copy of the Notice of
Privacy Practices for this office. ☐ Self ☐ Guardian

- **Signature** _____ Date: _____

Agreement to receive messages: I agree to receive information via email, text, or voice.

- **Signature** _____ Date: _____