## PATIENT INFORMATION

Full Name: _____ Birth Date: ___/___/___ Age: ___ Sex: ☐ M ☐ F

Address _____ City_____ State _____ Zip _____

Phone Numbers: Home _____ Cell _____ Work _____

E-Mail:_____ How did you hear about us? _____

### PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

☐Same as above

Name (Last, First) _____ Phone _____

Address _____ City_____ State _____ Zip _____

Payment Method (check one of the following)☐Cash☐Credit Card☐Check

### MEDICAL Insurance Information

Insurance Company: _____ ID #: _____

Member's Name: _____ DOB: ___/___/___ SSN: _____

Members Relationship to Patient: _____

### VISION Insurance Information

Insurance Company: _____ ID #: _____

Member's Name: _____ DOB: ___/___/___ SSN: _____

Members Relationship to Patient: _____

**As a courtesy to you, our clinic will submit claims to your insurance company for you.**
**However, we cannot accept liability for collecting your claim because the policy is a contract between you and your insurance company.**

Assignment and Release: I certify that I, &/or my dependent(s), have insurance coverage with the above listed insurance company and assign directly to Oregon Eye and Vision Center/Dr. Graham McPartland all insurance benefits, if any, otherwise payable to me for services/goods rendered. I acknowledge that this business is a service oriented business and that all services have an associated fee; further, I understand that I have the right to inquire about any/all fees prior to services being rendered so that I may make an informed decision. I acknowledge that I fully understand the contract that I have with my insurance company (i.e. co-pays, deductibles, etc), and I understand that it is not this businesses responsibility to understand my insurance contract. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor/clinic may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. **ALL COPAYMENTS AND OVERAGES ARE DUE AT THE TIME OF SERVICE.**

I have read and understand the above payment/insurance policy.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Print Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

IN CASE OF EMERGENCY, CONTACT _____

Phone Number(s): _____