



CONFIDENTIAL HEALTH INFORMATION

WELCOME TO OUR OFFICE

PATIENT INFORMATION

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(Please Print)

**IMPORTANT:** This questionnaire is to be reviewed at each appointment. Please answer all questions.

Patient Name: \_\_\_\_\_

Primary Vision Insurance: \_\_\_\_\_

Name preferred to be called: \_\_\_\_\_

Policyholders Name: \_\_\_\_\_

Address: \_\_\_\_\_

Policyholders Social Security #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of birth: \_\_\_/\_\_\_/\_\_\_ Relation to patient: \_\_\_\_\_

Date of birth: \_\_\_/\_\_\_/\_\_\_ Home Ph#: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Emergency Contact Phone #: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

I hereby authorize release of medical information to my insurance company and assign to Viking Vision Center all payments for services rendered to me or my dependents. This assignment will remain in effect until revoked by me in writing. Guidelines vary from plan to plan therefore I acknowledge that I am responsible to inform you at each visit what my insurance requires, such as referrals or pre-certification. I must provide a current insurance card with complete address for claims. I understand that regardless of my insurance status I am ultimately responsible for the balance of my account for any professional services rendered and/or materials ordered and I agree to pay such fees in full.

Patient's Signature :(Responsible Party) \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

**Financial Policy of Viking Vision Center**

1. Payment is expected at the time of visit.
2. All co-pays and material overages are due the day services are rendered or materials ordered.
3. The patient who seeks care is responsible for payment of all fees.
4. The person bringing a child into the office is responsible for the payment of all fees.
5. When we are not a provider for a third party, the patient who seeks care is responsible for the payment of all fees. We will provide a feeslip to submit to your third party for reimbursement directly to you. Initials
6. No patient will ever be refused care for financial reasons.

I have reviewed a copy of the office HIPAA policy. \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Doctor Use Only (reviewed at annual exam)

Clinician \_\_\_\_\_  No changes Date \_\_\_\_\_

Clinician \_\_\_\_\_  No changes Date \_\_\_\_\_

Clinician \_\_\_\_\_  No changes Date \_\_\_\_\_

Clinician \_\_\_\_\_  No changes Date \_\_\_\_\_