IN FOCUS EYECARE – Welcome Form

PATIENT INFORMATION

First Name MI Last Name Preferred Name

Address City State Zip

Date of Birth M or F Home Phone # Day Phone #

Email Address Person Responsible for Account

INSURANCE INFORMATION

Name of Primary Insurance Company Insured's Name

Insured's ID Number Group # Insured's Date of Birth

Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status ☐ Single ☐ Married ☐ Other

☐ Full-time Student ☐ Part-time Student ☐ Employed

PLEASE READ:

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices: I acknowledge that I have been presented with the Notice of Privacy Policy of Megan Fowles, O.D. and have been offered a copy of such policy to keep for my records.

Signature of Patient or Patient's legal representative Date

Permission to file Insurance/Self Pay Agreement: I authorize MEGAN FOWLES, O.D., (D.B.A. IN FOCUS EYECARE) A PROFESSIONAL OPTOMETRIC CORPORATION to release all information necessary to secure payment from my insurance company. If not covered by vision insurance, I agree to pay all exam fees, as determined by In Focus Eyecare, at the time of service.

Signature of Patient or Patient's legal representative Date