CLARUS
VISION CLINIC

First Name: _____ **Last Name:** _____ **DOB:** _____
How would you like us to address you: _____ **SSN :** _____
Mailing Address: _____ **Apt**:_____ **City:** _____
State: _____ **Zip Code:** _____ **Email Address**: _____
Marital Status: S M W Other **Gender:** M or F **Preferred Contact:** Mail Phone Email Text

Phone Numbers: Home: ( ) _____ **Cell**: ( ) _____

Ethnicity/Race: _____ or [prefer not to answer]

How did you hear about us?: Referring Doctor[Who]:_____ Family/Friend[Who]: _____

IF PATIENT IS UNDER 18 YEARS OF AGE, PLEASE COMPLETE THE FOLLOWING:

Parent or Guardian Name: _____ D.O.B:_____

Address: _____ City: _____

State: _____ Zip: _____ Phone: ( ) _____

Phon

Spouse Employer Name & Phone Number: _____

WHOM MAY WE CONTACT IN CASE OF AN EMERGENCY (person not living with you)?

Name: _____ Relationship: _____

Address _____ City: _____

State: _____ Zip Code: _____ Phone: ( ) _____

The following is NOT needed if we have a copy of your insurance cards.

Primary Insurance: _____ Name of Insured _____D.O.B:_____

Member ID: _____ Group Number: _____

Insurance Address: _____ Phone Number ( ) _____
Authorization Required: Y N

PATIENT OR GUARDIAN SIGNATURE _____ DATE_____

***Please Continue Filling Out the Backside**

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of Clarus Vision Clinic's privacy practices. I understand that the Notice described in it is subject to change at the discretion of Clarus Vision Clinic at any time. [Page 3 of paper work]

Please sign here_____

Financial Terms of Agreement

The following is an explanation of the Clarus Vision Clinic's financial terms of agreement which must be read and signed prior to receiving any medical care.

As a courtesy to you, we will submit your insurance claim if we are given the proper information for processing. If there are any problems with your insurance coverage, it is your responsibility, not ours, to resolve the matter with your insurance company. We encourage you to call you insurance with any unmet coverage.

- **I accept** full financial responsibility for fees incurred on my account in the office of Clarus Vision Clinic. **I will** pay my responsibility of the fees at the time of service, unless prior arrangements have been made with the office.
- **I request** payment of authorized insurance benefits be made on my behalf to my physician/supplier for any services furnished to me. **I authorize** the release of any medical or other information necessary to the insurance carrier and its agents to determine these benefits or the benefits payable for related services. **I authorize** use of my signature on all insurance claim submissions.
- **Repeat Billing Charges** will be assessed on balances 60 days older at 1.5% per month (annual percentage of 18%) with a minimum charge of $5.00 per month.
- **I agree** to pay all repeat billing charges as well as any collection agency fee not to exceed 50% of the original balance and **I agree** to pay all court costs, reasonable attorney fees and filing charges if any delinquent balance is placed with an agency or attorney for collection. A collection preparation fee of at least 35% of the balance will be assessed on the unpaid amount for which I am responsible.
- **I agree and understand** the above financial terms of agreement.

_____ _____

Date Print Patient's Name

_____ _____

Signature of Office Representative Signature of Patient