

Dr Rinearson

Dr Renner

Dr Warren

Dr Perry

Name _____ Sex M F .SS# _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone(h) _____ Phone(w) _____ Phone(c) _____ EMAIL _____

Marital Status: Single Married Widow Divorced Student ___ Retired ___ Employed ___ PT FT

Referred by _____

Employer _____ Address _____

RESPONSIBLE PARTY? _____ SS# _____ DATE OF BIRTH _____

Address, if different from patient _____ Phone _____ Relationship to patient self parent spouse

other

Other emergency Contact

Phone _____ Relationship _____

Payment today will be made by (circle one) Cash Check Master Card Visa Discover American Express

INSURANCE INFORMATION

Please present your insurance card(s) to the receptionist.

Primary Insurance

Company Name _____ Relationship to insured: ___ Self ___ Spouse ___ Child ___ Other

Subscriber's name (if different from yours) _____

Subscriber's SSN _____

Address _____ Birthdate _____

Secondary Insurance Company name _____

Subscriber's name (if different from yours) _____

Subscriber's SSN _____

Address _____ Birthdate _____

PATIENT AUTHORIZATION

I understand that I am responsible for total payment of services rendered to me, except services covered by insurance companies with which the office has a participating agreement. I authorize the office to apply for benefits on my behalf for covered services from these plans and/or Medicare, and that payment be made directly to the office. I understand, although I might be covered under a medical insurance policy, I am primarily responsible for payment of any charges due.

I further understand that I may require a referral depending upon my insurance plan in order for services to be covered in this office. If I do not bring a referral I understand that I am responsible for all charges incurred at this office.

The **refraction and any contact lens portion** is often not a covered service but is necessary to determine the prescription for glasses or to monitor medical and surgical treatment. I will be responsible for these fees if they are not covered by my insurance plan.

I understand that if payment is not received within 90 days of the date of service, from me or my insurance company, the account will be turned over to a collection agency. I understand that if I agree to make monthly payments and the account becomes delinquent for 90 days, it will be turned over to a collection agency. I understand that if I have borrowed equipment, glasses, contacts or other materials from the office that I am responsible for returning them in good condition or I will be charged the full amount for these items. There will be an administrative charge of \$50.00 added to the balance of any unpaid portion of the bill for any account turned over to the collection agency.

I certify that the information provided on this sheet is correct and I authorize the release of any necessary information, including medical information, for this or any related claim. I permit a copy of this authorization to be used in place of the original. The authorization may be revoked by me, in writing, at any time.

I have received a copy of the office privacy practices.

Signature of patient/parent or guardian

Date

Robin Rinearson, O.D.
Christopher Renner, O.D.
Robert Warren, O.D.
W. Dodge Perry O.D.
5653 Columbia Pike
Bailey's Crossroads, VA 22041
703-578-3600

You may refuse to sign this acknowledgment

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For office use only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited us from obtaining acknowledgment
- Other (Please specify)

_____ Employee signature