

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) \_\_\_\_\_ E-Mail \_\_\_\_\_

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:** **Cash** **Check** **MasterCard** **Visa** **Discover** **American Express**

**INSURANCE INFORMATION**

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

**Primary Insurance**

Company \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ to insured: **Self** **Spouse** **Child** **Other** \_\_\_\_\_

Subscriber's name (if different from yours) \_\_\_\_\_

Subscriber's SS# \_\_\_\_\_

Subscriber's Address \_\_\_\_\_ Birthdate \_\_\_\_\_

**Secondary Insurance**

Company \_\_\_\_\_  
Name \_\_\_\_\_

Subscriber's name (if different from yours) \_\_\_\_\_

Subscriber's SS# \_\_\_\_\_

Subscriber's 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