WELCOME TO JENSEN EYE CARE

Thank you for selecting our eye care team. Our goal is to provide you with the best possible eye care. Please fill this form out completely. If you have any questions please ask!

How did you hear about us? _____ Today's Date_____

PATIENT INFORMATION:

Legal First Name: _____Last Name:_____MI:_____

Preferred Name: _____Primary Phone #:_____E-mail:_____

Social Security #: _____ Birth Date: _____ Age: _____

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Ethnicity: ☐ Caucasian/White ☐ Hispanic ☐ African American

☐ Native American ☐ Asian/Pacific Islander ☐ Other

Mailing Address: _____ City:_____ St:_____Zip:_____

Employer: _____Occupation: _____

Primary Care Physician: _____Pharmacy:_____

EMERGENCY CONTACT:

Name:_____ Relationship:_____Phone #:_____

INSURANCE:

It is the patient's responsibility to let us know who their insurance provider is before services are rendered. We accept ***Vision Service Plan (VSP), Medicaid, CHIPS, and Medicare***.

We will courtesy file with BCBS and United Health Care, with payment required at time of service. Please present insurance card at time of check in.

For insurances other than those mentioned above, we will provide you with a detailed receipt to send to your insurance company for reimbursement. Any reimbursement from your insurance company will be mailed directly to you.

PAYMENT:

Payment is due at time of service. We require at least half down on all materials and the other half before dispensing. We accept all major credit cards and Care Credit.

MISSED APPOINTMENT POLICY:

Rather than charge a missed appointment fee, we require a 24 hour advance notice if you cannot make your scheduled appointment. If an appointment is missed without notifying our office within 24 hours, you will need to call for a same day appointment, subject to availability.

FEDERAL HIPAA PRIVACY ACT

As per the Federal HIPAA Privacy Act, Jensen Eye Care will not share medical information with anyone without written consent from the patient. If you, as the patient, desire we share medical information about you with anyone, please inform us so that we may provide you with a Release of Information Form to sign. If you would like a copy of the Federal Privacy Act you may ask for it at the front desk.

I acknowledge that I understand the insurance, payment and missed appointment policies. I also acknowledge that I was offered a copy of the HIPPA Policy.

Signature: _____Date:_____