

SEATTLE VISION CARE

PATIENT UPDATE

Name: _____

Preferred Nickname: _____

Current Address: _____

Email Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Current Medical Insurance: _____

Current Vision Insurance: _____

Any changes to your health history: _____

Current Employer: _____ Occupation: _____

Spouse/Partner

Marital Status: Married Domestic Partner Single Name (if applicable): _____

Seattle Vision Policies Agreement

- Most major insurance companies can be billed directly through our office. Please provide us with an ID card so that we may contact your insurance company for a quote of benefits and eligibility. **Your portion of the balance is due at the time of your visit in our office.**
- If you wear contact lenses, the required fitting exam and followup may not be a covered benefit with your insurance company. **This portion of your exam is necessary to ensure proper fit of your contacts and to evaluate your vision while wearing the contacts.**
- Our office requires 24 hours notice for all cancellations or rescheduling of appointments. **If you do not give 24 hours notice you will be charged a flat \$50 fee.**
- **All sales are final.**

I the undersigned have read and understood my HIPAA rights on the next page and our office and payment policies as stated above

Signature: _____ Date: _____

Witness: _____ Date: _____