Welcome To
Oregon Vision Center
Patient Information

Last Name _____First Name_____Middle Initial___

Date of Birth_____/_____/_____Social Security_____-_____-_____Female_____Male_____

Mailing Address _____ _____

City _____State_____Zip_____Phone_____

E-Mail_____ _____

Primary Insurance_____Insured's Name_____

Insured's Identification Number_____Group Number_____ Insured's DOB_____

Insured's Social Security_____-_____-_____Employer_____

Whom may we thank for referring you to our office?_____
Family_____Friend_____Phone book_____Internet_____ Other_____

AUTHORIZATION

In order to control the cost of billing, we ask that the Patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. All accounts 30 days past due are subject to accrued interest fees. Accounts 90 days past due are subject to collection fees. There will be a service charge on all returned checks.

Payment from my primary insurance is to be paid directly to Dr. Tom Thomason or Oregon Vision Center. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. INITIAL___

ACKNOWLEDGMENT AND CONSENT

I understand that Dr. Tom S. Thomason and Oregon Vision Center may use and disclose health information about me. I understand that I have the right to receive and review a written description of how Dr. Tom S. Thomason and Oregon Vision Center will handle health information about me. This written description is known as a Notice of privacy practices and describes the uses and disclosures of health information made and the information practices followed by employees, staff, and other office personnel of Dr. Tom S. Thomason and Oregon Vision Center and my rights regarding my health information. I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that Dr. Tom S. Thomason and Oregon Vision Center is not required by law to agree to such request. By signing below, I agree that I have reviewed and understand the information above.

Printed Name _____ _____
Patient or Patient Representative

Signature _____ _____Date_____/_____/_____
Patient or Patient Representative