Tashner Vision Clinic LLC

Date _________ Last Name __________________ First ____________ Middle Int. ___ DOB _________

Address __________________________________ City _______________ State _____ Zip__________

Home Phone _________________ Cell Phone _________________ Work Phone _________________

Medical Insurance: ___________________________ Vision Insurance ___________________________

Primary Care Physician ____

Email Address ____

Release of Information

I authorize the release of my personal information to the following:

{ } Spouse ___________________ { } Child ___________________ { } Other _______________

{ } Information is not to be released to anyone.

Records Release

{ } I authorize release of any medical or other information necessary to correspond with medical and/or vision payers.

{ } Past health and vision records from: ____

Notice of Privacy Practice and Filing for Insurance

I acknowledge that I was offered and/or received a copy of Tashner Vision Clinic, LLC, notice of privacy practice. I authorize payment of any available benefits to Tashner Vision Clinic. I understand that medical health insurance coverage and/or vision plan coverage does not guarantee payment in full for services rendered or material purchases, I accept responsibility for any services or materials for which no payment is made or not covered by any medical health insurance and/or vision plan.

____

Print Name

____

Patient Signature (If signed by other than individual, select relationship) Date

{ } Parent { } Legal Guardian { } Other ____

PAYMENT DUE IN FULL AT TIME OF SERVICE
50% FEE WILL BE CHARGED FOR ALL CANCELLED ORDERS

This authorization is valid until a written request is submitted to end the authorization for release.
This is specific to the release of request not the acknowledgement of receiving a copy of Privacy Practice.