Welcome to BarKing Optical

Patient Financial and Insurance Information

PATIENT NAME:_____ **NICKNAME**_____
(PLEASE PRINT) LAST NAME FIRST NAME MIDDLE INITIAL

DATE OF BIRTH: (MM/DD/YY)_____/_____/_____ **AGE**_____ **SSN#**_____ **GENDER: MALE / FEMALE**
(PLEASE CIRCLE)

ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP:**_____

HOME PHONE:_____ **CELL PHONE:**_____**WORK PHONE:**_____

E-MAIL ADDRESS:_____
PLEASE CIRCLE ONE: **SINGLE** **MARRIED** **WIDOWED** **DIVORCED**

EMERGENCY CONTACT PERSON AND NUMBER_____

PERSON(S) WE CAN DISCUSS AND/OR RELEASE YOUR HEALTH INFORMATION TO: Self only ____ Name(s)_____

May we email/text about appointments or other health information? YES_____ NO_____

EMPLOYER:_____ **OCCUPATION:**_____

***** A NOTE TO ALL OUR CONTACT LENS WEARERS*****

In most cases contact lenses are not considered **medically necessary** by insurance companies. Any test performed to determine or update a contact lens prescriptions **may not** be covered by insurance companies and will be the responsibility of the patient.

VISION INSURANCE
NAME OF INSURANCE_____ **ID#** _____
SUBSCRIBER INFORMATION
NAME:_____ **DATE OF BIRTH**_____ **LAST 4 OF SS#**_____

RELATIONSHIP TO PATIENT:_____ **PHONE NUMBER**_____

MEDICAL INSURANCE
NAME OF INSURANCE_____ **ID#**_____
SUBSCRIBER INFORMATION
NAME:_____ **DATE OF BIRTH**_____ **LAST 4 OF SS#**_____

RELATIONSHIP TO PATIENT:_____ **PHONE NUMBER**_____

Medical Release Authorization and Insurance Assignment:
I, the undersigned authorize payment from my insurance company to be made to BarKing Optical, Inc. for covered services. I understand that I am responsible for obtaining any referrals needed before my appointment or I must pay for that visit. Regardless of my insurance status, I am ultimately responsible for the balances of my account.
Should timely payments of this account not be made, I authorize BarKing, Inc. to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance. Any expenses incurred by such action shall become an additional liability for which I am responsible. I certify that the information, including medical information, to my insurance company in order to determine insurance benefits to which I may be entitled, this authorization may be revoked by myself at any time in writing.
I have reviewed a copy of the Privacy Practice Notice (located on the wall) at BarKing Optical, Inc.

PRINT NAME **SIGNATURE** **DATE**