Fox Cities Eye Clinic, SC

1301 E Northland Avenue - Appleton, WI 54911 - (920) 734-8714

Name: _____DOB:_____Phone:_____Cell:_____

Address: _____City/State:_____ZIP:_____

Employer:_____ May we contact you at work: YES NO Phone:_____

Emergency Contact:_____Relationship:_____Phone #:_____

Name of Insurance:_____ Social Security #: _____

How Did you hear about us? Family/Friend Internet Referred by Dr. Other:_____

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Race (Please circle one) White Asian Black/African American Hispanic Unknown Decline

Language: (Please circle one) English Spanish Hmong Other_____ Decline

Ethnicity: (Please circle one) Non-Hispanic Hispanic/Latin Other_____ Decline

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We submit insurance claims as a courtesy to our patients.
However, the patient is responsible for all fees regardless of insurance coverage.

There have been many changes within the healthcare insurance industry. It is impossible for Fox Cities Eye Clinic to Know or verify if our office is covered by your plan. It is therefore, your responsibility to check with your insurance Carrier to see whether your particular insurance plan covers Fox Cities Eye Clinic.

I hereby authorize Fox Cities Eye Clinic (FCEC) to release any medical information necessary to determine benefits payable for related services to process the claim. I authorize FCEC to submit to my insurance. I assign payment directly to FCEC for any medical/surgical procedures performed.

I also acknowledge full responsibility for payment of services and agree to pay for them in full.

Acknowledgement of Receipt of Notice of Privacy Practices

This notice describes how FCEC may disclose my protected health information (PHI), certain restrictions on the use and disclosure of my health care information, and rights I have regarding my protected health information.

The Privacy Laws allows our clinic to speak to you only, regarding billing information or medical records. If you choose you are able to authorize family members or a friend to have access to this protected information:

I _____, authorize:_____
(Patient Name)

To discuss my: (please circle) Billing Information Medical Records To be in the Exam Room with me

I acknowledge that the NEW (09/20/13) Privacy Policy has been made available to review and/or keep if I choose to do so.

_____Date:_____
Signature of patient or legal representative