

# 5280 Vision Care

Trisha C. Rogers, O.D.

Helen R. Wilson, O.D.

9220 Kimmer DR #140 Lone Tree, CO 80124

303-754-0122

PLEASE PRINT and COMPLETE ALL PARTS

**PATIENT NAME:** (this Section refers to PATIENT ONLY)

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex M F E-Mail \_\_\_\_\_

Marital Status Married Single Divorced Widowed (Please circle one)

Social Security # (if used for insurance identification) \_\_\_\_\_

Employer \_\_\_\_\_

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor. Insurance is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is the patient's responsibility to pay any deductible amounts, coinsurance, or any other balance not paid for by your insurance.

**PLEASE READ AND SIGN THE FOLLOWING:** I directly assign all medical benefits to 5280 Vision Care and understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**INSURANCE** (Please fill out below and we will copy any insurance cards and your driver's license)

Vision Insurance: \_\_\_\_\_

Primary Medical Insurance: \_\_\_\_\_

Secondary Medical Insurance: \_\_\_\_\_

Name and Date of Birth of Primary Insured: \_\_\_\_\_

SSN of Primary Insured if used as insurance ID: \_\_\_\_\_

**NOTIFY IN EMERGENCY:**

Name \_\_\_\_\_ Best Contact Number \_\_\_\_\_

I UNDERSTAND THAT MEDICARE, MEDICAID, AND MOST OTHER INSURANCE COMPANIES WILL NOT COVER THE COST OF AN EYE REFRACTION AND THAT THIS CHARGE WILL BE MY RESPONSIBILITY.

SIGNATURE \_\_\_\_\_ Date: \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES:**

I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF DR HELEN R WILSON'S CURRENT NOTICE OF PRIVACY PRACTICES. (these can be viewed on our website or in the office)

SIGNATURE \_\_\_\_\_ Date: \_\_\_\_\_