

ADMINISTRATIVE OFFICE
P.O. Box 1800
Waldorf, Maryland 20604
(301) 843-1000
info@doctorsonsight.com



Locations in:

Waldorf • California • Prince Frederick • Bowie • Marlow Heights • Germantown • Tysons Corner • Springfield • Massaponax

PATIENT'S NAME:					
PATIENT'S HOME ADDRESS:					
PATIENT'S CONTACT INFORMATION					
HOME TELEPHONE:			WORK:		
CELL:		PAGER:		EMAIL:	
SEX:		DATE OF BIRTH:		SSN:	
EMPLOYER/ADDRESS				OCCUPATION	
EMPLOYER/ADDRESS				SCHOOL/GRADE	
REASON FOR VISIT?					
PRIMARY INSURANCE INFORMATION			SECONDARY INSURANCE INFORMATION		
PLAN NAME:			PLAN NAME:		
SUBSCRIBER:			SUBSCRIBER:		
SUBSCRIBER'S BIRTH DATE (REQUIRED):			SUBSCRIBER'S BIRTH DATE (REQUIRED):		
SUBSCRIBER'S SSN (REQUIRED):			SUBSCRIBER'S SSN (REQUIRED):		
RELATIONSHIP OF PATIENT TO SUBSCRIBER:			RELATIONSHIP OF PATIENT TO SUBSCRIBER:		
PLAN ID:			PLAN ID:		
GROUP ID:			GROUP ID:		
<p>NOTE: A copy of your health plan identification card is required at each visit. Please give the card(s) to the receptionist for photocopying and confirmation of benefits. YOUR CARD MUST BE PRESENTED AT EACH VISIT. YOUR COPAYMENT MUST BE PAID AT THE TIME OF SERVICE.</p>					
<p>NOTICE OF PRIVACY POLICIES: Our office takes measures required by federal law to protect your privacy rights as our patient. As required, we have a policy in place to protect your personal health information as much as reasonably possible for the continuity of your medical care. Our policy is available for your viewing in our waiting area, or you may have a copy for your records. You also have the right to limit access to your information by others. If you would like a copy of our privacy policy to take with you, please request it from our receptionist.</p>					
<p>With my signature below, I have read and understood the above. I understand I may view the policy as posted in the waiting area, or I may have a copy for my records. I would like a copy of the Privacy Policy. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
Patient, Parent or Legal Guardian's Signature			Today's Date		Office Clerk's Signature:
<p>OFFICE POLICY, INSURANCE AUTHORIZATION, AND ASSIGNMENT</p> <p>I HEREBY AUTHORIZE DOCTORS ON SIGHT® OPTOMETRISTS, INC. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS, AND I HEREBY ASSIGN TO THE DOCTORS ALL PAYMENTS FOR EYE CARE SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT. THE PATIENT IS RESPONSIBLE FOR ALL FEES, INCLUDING ANY AMOUNT NOT COVERED BY INSURANCE. THERE ARE NO REFUNDS FOR ANY PROFESSIONAL SERVICES OR OPTICAL MATERIALS. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. IT IS CUSTOMARY TO PAY FOR SERVICES AS THEY ARE RENDERED. I ALSO AGREE TO PAY IN THE EVENT OF NON-PAYMENT; TO BE RESPONSIBLE FOR THE COST OF COLLECTIONS, AND OR COURT COSTS AND ANY REASONABLE LEGAL FEES SHOULD THIS BE REQUIRED.</p>					
PATIENT'S SIGNATURE:				DATE:	
PARENT'S SIGNATURE IF PATIENT IS A MINOR:					

