WELCOME!

Twenty/20 Vision Care
Dr. Craig Fenimore, OD
1818 N Main St
Rushville, IN 46173

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female Date _____

☐ Single ☐ Married ☐ Other ☐ Full-time Student ☐ Part-time Student ☐ Employed

First Name _____ MI _____ Last Name _____ Preferred Name _____

Address _____ City _____ State _____ Zip _____

Birthdate _____ SSN _____ Primary Phone (_____) _____-_____

Email _____ Person Responsible for Account _____

How were you referred to our office? ☐ Phone Book ☐ Insurance ☐ School ☐ Drive by ☐ Advertisement ☐ Other

Who were you referred by? _____

PRIMARY INSURANCE INFORMATION

Spouse's Name (or legal guardian) _____ Birthdate _____ SSN _____

Do you wear glasses now? Yes No Always Occasionally Reading Driving TV Do you have them with you? Yes No

Do you wear contacts now? Yes No Always Occasionally Reading Driving TV Do you have them with you? Yes No

Primary Reason for Visit _____

PLEASE READ:

I, the undersigned, certify that I (or my dependent) have insurance coverage. I authorize Dr. Fenimore to release to my insurance carriers, including Medicare and Medicaid, any information required to file or resubmit my claim. I authorize my insurance companies to pay Dr. Fenimore directly on my behalf for services rendered. I authorize all insurance companies including Medicare Supplements and Medicaid to provide any information to Dr. Fenimore that is required to resubmit any denied or incorrectly paid insurance claims. I understand that I am financially responsible for all charges, including: the deductibles, coinsurances, non-covered materials, and non-covered medical procedures provided by Dr. Fenimore, whether or not paid by my insurance. ***There are network provider benefits that we are unable at this time to file and receive payment from; we will collect the pertinent information required from you to file the claim on your behalf. We require FULL payment on this type of claim.***

I authorize the use of this signature on all insurance submissions (CMS-1500 claim form, on other approved claim forms or electronically-submitted claims) and this authorization remains in effect until withdrawn by me.

Patient or Guardian's Signature _____ Date _____

HIPAA NOTICE OF PRIVACY POLICIES

I acknowledge that I have read and/or received Twenty/20 Vision Care's Notice of Privacy Practices.

Patient or Guardian's Signature _____ Date _____