Chancellor Eye Care

12100 Kennedy Lane
Fredericksburg, VA 22407
William R. Kossol, O.D 540-785-3937 Sarah E. Pilat, O.D., F.A.A.O

PATIENT INFORMATION

Last Name:_____ **First Name:**_____ **MI:**_____

Address:_____ **City & State:**_____ **Zip Code:**_____

Home Phone:_____ **Date of Birth:**_____ **Sex:** Male / Female

Marital Status: Single Married Divorced Widowed **Social Security #:**_____ **Email:**_____

Employer:_____ **Work Phone:**_____ **Cell Phone:**_____

Communication Preference: Email Mail Phone **Race:**_____ **Preferred Language:** English or Spanish **Ethnicity:** Hispanic or Latino Native Hawaiian Pacific Island Not Hispanic or Latino

EMERGENCY CONTACT

Last name:_____ **First Name:**_____ **MI:**_____

Relationship to Patient:_____ **Home Phone:**_____ **Work Phone:**_____ **Cell Phone:**_____

INSURANCE INFORMATION

Vision Insurance:_____

Policy Holder Name:_____

Date of Birth:_____ **SS#:**_____

Relationship to Patient:_____

Primary Medical Insurance:_____

Policy Holder Name:_____

Date of Birth:_____ **SS #:**_____

Relationship to Patient:_____

Secondary Medical Insurance:_____

Policy Holder Name:_____

Date of Birth:_____ **SS #**_____

Relationship to Patient:_____

Third Medical Insurance:_____

Policy Holder Name:_____

Date of Birth:_____ **SS #:**_____

Relationship to Patient:_____

Our Financial Policy: Payment is due at the time of service. Copayment, coinsurance and applicable deductible are patient responsibility. Your insurance policy is a contract between you and your insurance company. As a service to you, we will file the claim to your insurance company if we are a participating provider. If your insurance company does not pay Chancellor Eye Care within a reasonable period, we will have to look to you for payment. If we receive payment from your insurance after payment is made from you, we will refund any overpayment due to you. All services are not covered by all insurance plans. If any of the services rendered to you are denied by your insurance company stating "non-covered", you will be responsible for the complete charge. Payment is due upon receipt of a billing statement from our office. If you are due a refund, our office processes refunds once a month. Responsible Party Initial: _____

I have received or have been offered a copy of the Notice of Privacy Practices. Responsible Party Initials: _____

Signature of Responsible Party: _____ Date: _____