Chancellor Eye Care

12100 Kennedy Lane Ste 206 - Fredericksburg, VA 22407 - 540-785-3937

Sarah Pilat Brannon, O.D., F.A.A.O. — Sonia Joshi Rose, O.D.

PATIENT INFORMATION

Last Name: ____________ **First Name:** ____________ **MI:** ______

Address: ____________ **City & State:** ____________ **Zip:** ______

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

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

Employer/Occupation: ____________ **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: ____________	**Primary Medical Insurance:** ____________
Policy Holder Name: ____________	**Policy Holder Name:** ____________
Date of Birth: ______ **ID#:** ______	**Date of Birth:** ______ **ID#:** ______
Relationship to Patient: ____________	**Relationship to Patient:** ____________
Secondary Medical Insurance: ____________	**Third Medical Insurance:** ____________
Policy Holder Name: ____________	**Policy Holder Name:** ____________
Date of Birth: ______ **ID#:** ______	**Date of Birth:** ______ **ID#:** ______
Relationship to Patient: ____________	**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 Initial:* ______

Signature of Responsible Party: ____________ Date: ____________

MEDICAL RECORDS RELEASE

I hereby authorize Chancellor Eye Care to disclose my care, records and any prescription information to the following person(s), provider and institution:

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This authorization expires one year from date of signature.

Patient/Guardian Signature: ________________________________

Patient Name (please print): ________________________________

Date: ____________________