Dale N. Holdren, MD
K. Scott Sorensen, MD
Preston Sullivan, MD

Kitsap Eye PHYSICIANS

Jason G. Gagnon, OD
Debra M. Sorensen, OD

PATIENT/MINOR INFORMATION

Last Name: _____ First Name: _____ MI: ___

SSN # _____ DOB: _____ ☐ Male ☐ Female

Mailing Address: _____
Street/PO Box # City State Zip Code

Physical Address: _____
Street/PO Box # City State Zip Code

Home Phone: _____ Cell Phone: _____

Parent/Guardian: _____ Phone: _____

ADDITIONAL PATIENT INFORMATION

Race / Ethnicity- Please mark all that apply:

American Indian / Alaskan Native
Native Hawaiian / Pacific Islander
Other: _____
African American
Hispanic / Latino
Declines
Caucasian
Asian

Primary Language:

English Spanish Other: _____

PATIENT PRIVACY DISCLOSURE

In addition to the allowable disclosures in the notice of Privacy Practices, I hereby specifically authorize disclosure of my protected healthcare information to the person(s) indicated below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

In case of EMERGENCY contact:

Name: _____ Phone: _____

May we leave a message on your answering machine and/or voicemail? [ ] Yes [ ] No

Patient/Guardian Signature: _____ Date: _____

Please read and sign the other side

KITSAP EYE PHYSICIANS FINANCIAL POLICY

Thank you for choosing **Kitsap Eye Physicians** as your healthcare provider. We are committed to providing excellent eye care in our relationship with you. The following is a statement of our **Financial Policy**, which we request you read and sign prior to treatment. All new patients must complete our **Information and Insurance Form** before seeing the doctor. If you do not have any vision or medical coverage, payment is due at the time of service.

INSURANCE
We will bill your insurance company as a courtesy to you. We accept assignment of insurance benefits for Washington State insurance plans with which we are contracted. If you are not covered by one of these plans, then you are expected to pay at the time of service. We can not bill your insurance company unless you provide us with all of your information accurately at the time of service. We are required by your insurance company to collect your co-pay at the time of service. Please be aware that some insurance companies may be limited in their coverage and therefore may consider some services to be non-covered. You are responsible for any remaining balance after we receive notification from your insurance company. If we have not received payment from your insurance company within 60 days of service, we will transfer the balance to you, the patient. We accept: cash, checks, Visa, Mastercard, Discover, and CareCredit.

WORKERS COMPENSATION
If you are here as a result of a work related injury, you need to provide us with the correct workers compensation plan and address to bill. If payment is not received after 60 days, the balance is you responsibility.

NONPAYMENT
If your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full or make payment arrangements with us. Please be aware that if your balance remains unpaid, we reserve the right to refer your account to a collection agency and you will be responsible for any additional charges accrued by the collection agency.

MINOR PATIENTS
A parent/guardian must give consent for a minor to be examined or treated. The parent/guardian that brings the minor in to be treated will be the responsible party for any unpaid balance.

PARENT/GUARANTOR INFORMATION

Last Name: _____ First Name: _____ MI ___

DOB: _____ SSN: _____

Address: _____
Street/PO Box # City State Zip Code

Phone: _____ Insurance Name: _____

Employer: _____ Work Phone: _____

AUTHORIZATIONS TO RELEASE INFORMATION AND ASSIGMENT OF MEDICAL BENEFITS

I hereby authorize Kitsap Eye Physicians to treat the patient named below. I authorize the release of medical information necessary to process insurance claims for treatment. Photocopies of these are valid as the original.

I authorize medical benefits to be directly paid to Kitsap Eye Physicians. I understand that I am financially responsible for any treatment not covered by my health insurance.

Patient Name: _____ Patient DOB: _____
Please Print Name

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____