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## Welcome To Boise Vision Care!

Patient Name: \_\_\_\_\_ Primary Insurance: \_\_\_\_\_  
Address: \_\_\_\_\_ Insurance ID: \_\_\_\_\_  
\_\_\_\_\_  
Name of Primary Subscriber: \_\_\_\_\_  
\_\_\_\_\_  
Subscriber's Date of Birth: \_\_\_\_\_  
Home Ph: \_\_\_\_\_ Pt's Employer Name: \_\_\_\_\_  
Daytime Ph: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Provider: \_\_\_\_\_  
SSN#: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
If bringing a child, Responsible Party: \_\_\_\_\_  
Responsible Party's SSN#: \_\_\_\_\_

### Consent Form

#### Acknowledgement of Receipt of Privacy Policies – HIPPA

I acknowledge that I reviewed a copy of the **Notice of Privacy Practices** for this office.

#### Insurance Authorization and Patient Responsibility

- I request that payment of authorized insurance benefits for any services furnished me, be made on my behalf to Boise Vision Care, P.A.
- I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.
- I understand that I am responsible for fees not paid by my insurance. Unpaid balances over 30 days will incur a minimum \$3 fee. Any balance over \$100 will be assigned a 3% monthly finance fee.

#### **Release of Medical Records**

- I authorize Boise Vision Care to release / request my medical records to / from any previous providers.

Print Patient Name: \_\_\_\_\_

Signature of Parent for a minor: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_