Name_____DOB_____Chart #_____Date_____
AGE_____

Precision Optical, PC

Timothy Ross, OD Chris Stephenson, OD Patrick Stow, OD

Receipt of Notice of Privacy Practices Written Acknowledgment Form

I, _____have reviewed/received a copy of
Precision Optical PC's Notice of Privacy Practices.

_____ _____
signature of patient/guardian Date

Information of Policy Holder or Person Responsible
(circle one) self spouse parent/guardian
Full name_____SS#_____

Employer_____ Date of Birth_____

Insurance Company_____ Group #_____

Name of relative not living with you
_____
Name address phone

Do you have a secondary insurance?_____

I authorize the release of information relating to all claims for benefits submitted on behalf myself or my dependents. My signature on this document authorizes Precision Optical PC to submit insurance and/or Medicare claims for benefits on services rendered, to be rendered, and/or on materials furnished. I certify the information given by me is true and correct. I hereby assign payment directly to Precision Optical PC for these benefits. I understand that I am financially responsible for all charges incurred, including unpaid insurance claims. Co-pays, deductibles, and non-covered amounts are due when services are rendered. There will be a finance charge of up to 1.5%/mo. Applied to any balance that is unpaid. Verification of benefits does not guarantee payment. I give Precision Optical PC all authority necessary to perform diagnostic and therapeutic procedures for my best ocular health. This includes dilation, which may produce side effects and allergic reactions. Please sign below. If you are under 18, a parent or guardian must sign.

_____ _____
signature date

Whom may we thank for referring you?_____

NCT
OD_____
OS_____

Present Spectacle Correction
OD_____
OS_____