

Please raise any questions about our contact lens fees and policies, release of prescriptions, insurance coverage amounts, or any other concerns to the technician prior to seeing the doctor.

Patient Information

Last Name:		
First Name:	Middle:	
Address:		
City:	State:	Zip:
Home Phone:		
Cell Phone:		
Work Phone:		
Email address:		
Sex: M F	Date of Birth:	Age:
Social Security:		
Employer / Occupation:		
Driver's License #:	State:	
Name of Vision Insurance:		
Name of Insured:		
Insured SS#:	Insured's DOB:	

Parent / Guardian Information (if patient is under 18)

Title: Mr Mrs Ms Dr	Nickname:	
Last Name:		
First Name:	Middle:	
Address:		
City:	State:	Zip:
Home Phone:	Work Phone:	
Cell Phone:		
Email address:		
Sex: M F	Date of Birth:	Age:
Social Security:		
Employer / Occupation:		
Driver's License #:	State:	

Whom may we thank for sending you to our office?

All vision insurance must be pre-approved prior to your examination. **If we are unable to verify coverage, all charges must be paid in full when services are rendered.** If you are not eligible for insurance benefits, or are eligible for less than full coverage, your signature below indicates that you agree to be financially responsible for any unpaid balance. **All remaining balances are your responsibility and will be paid to Dr. Shannon & Associates within 30 days of notification. Payments not received within 30 days will be charged to the responsible party via credit card on file.** Professional fees for services are non-refundable.

Signature of patient or responsible party: (Persons under 18 may not sign)	Printed Name:	Date:
--	---------------	-------

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Dr. Bridget A. Shannon & Associates make every effort to inform you of your rights related to your personal health information. By signing below, I acknowledge that:

- (Agree) I was given the opportunity to read Dr. Bridget A. Shannon & Associates Notice of Privacy Practices and wish to continue my care with Dr. Bridget A. Shannon & Associates under said terms.
- (Disagree) I have read or had explained to me Dr. Bridget A. Shannon & Associates Notice of Privacy Practices and do not wish to continue my care with Dr. Bridget A. Shannon & Associates under said terms.
- The Notice of Privacy Practice could not be read due to the emergent nature of the care or other reason described as

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient _____ Date _____

If you are signing as a personal representative of the patient, please indicate your relationship.

Representative _____ Relationship to Patient _____