Welcome to Altig Optical. Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that all the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name _____ MI _____ Last Name _____ Preferred Name _____

Street Address _____ City _____ State _____ Zip _____

Social Security Number _____ Date of Birth _____ Home Phone - include area code _____ Day phone _____

Email Address _____ Guardian _____ Person Responsible for Account _____

Emergency Contact _____ Emergency Phone _____

How were you referred to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient

☐ Insurance Listing ☐ Drive by ☐ Other ☐ Doctor

Who were you referred by? _____

Primary Insurance Information

Name and Address of Primary Insurance Company _____

M ☐ F ☐ Insured's First Name _____ MI _____ Insured's Last Name _____

Insured's identification Number _____ Group Number _____ Insured's Date of Birth _____

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status ☐ Single ☐ Married ☐ Other

☐ Full Time Student ☐ Part Time Student ☐ Employed

HIPAA PRIVACY REGULATIONS: Federal law, the Health Insurance Portability and Accountability Act of 1966, authorized the Department of Health and Human Services to adopt new rules to protect patient privacy. Notification is therefore given that the office of Altig Optical will not reveal to any person personal information about you or about a family member (i.e. name, address, Social Security Number, as well as other health information) without permission. While we will take every reasonable step to protect your personal information, some incidental disclosures such as calling your name in the waiting room or optical may occur. Your information will never be sold, or listed for the purpose of advertisement, solicitation or fund raising. Is it however understood that within the realm of doing business and for general patient care purposes, your personal information will be necessary and used in the following context: patient registration; Procedure medical records from former physicians; Converse with colleagues for opinions/care; Insurance: relating to patient care; Pursue collection of unpaid bills; Hospital workers, nurses, aids, and medical record departments; Emergency officials, Paramedic, fire personnel, emergency room physicians, nurses or technicians; Personal Religious designate; Pharmacists, drug program personnel/workers; completion of disability forms; Computer and electronically stored information (i.e. related business vendor and service persons) *I authorize the release of this necessary information* in order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and materials are charged to subject of collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to Altig Optical. I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed

Signature _____ Date _____