WELCOME TO OUR OFFICE

Thank you for choosing ***Boas Vision Associates*** for your eye care.

Date: _____

Name: _____

Address :_____

SSN: _____ Date of Birth: _____ Gender: M/F

(C): _____ ☐ txt. Email address: _____

Parents names if patient is a minor: _____

First-time patients, how were you referred? (patient, sign, insurance list, etc.): _____

If you were referred by a Patient, whom may we thank? _____

HIPAA Consent (Please provide us with the name(s) of any person(s), other than yourself, who you giveBoas Vision Associates permission to discuss your Personal Health Records with.)

_____

(Name) (Phone Number) (Relationship to Patient)

Notice of Privacy Practices

I have received and reviewedBoas Vision Associates policy regarding the use of my protected health information in their "*Notice of Privacy Practices"*.

Signature of Patient (or parent if a minor) _____ Date _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge and the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Boas Vision Associates to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such eyecare to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Boas Vision Associates insurance benefits otherwise payable to me. I agree to be responsible for and pay directly to Boas Vision Associates any charges not covered by my insurance coverage. I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I understand that a 1.5 % per month charge will be added to all balances over 30 days in addition to late fees. I further understand that all delinquent accounts (over 120) days will be sent to collection and I will incur the costs involved.

Signature of Patient (or parent if a minor) _____ Date _____