TREASURE VALLEY EYECARE

Brittany Highsmith, O.D.

Micah S. Mills, O.D.
Residency Trained Optometric Physician

Dr. Mr. Mrs. Ms (circle one)
Patient Name (Last)_____ (First)_____ (MI) _____
Address _____
City_____**State** _____**Zip Code** _____
Home Phone _____**Cell Phone** _____**Day Phone**_____
Date of Birth _____ **Social Security #** _____
Email _____

RACE: _____American Indian ____Asian _____Black or African American ____White _____Declined
ETHNICITY: _____Hispanic or Latino _____Not Hispanic or Latino _____ Declined
Language: _____English _____Spanish _____Other_____

WORK/INSURANCE
Employer: _____

Primary Insurance: _____ **ID#** _____
Subscriber Name: _____ **DOB:** _____
Secondary Insurance: _____ **ID#** _____
Subscriber Name: _____ **DOB:** _____

Preference for Appointment/Special Offers: _____Email _____Telephone _____Mail _____Text
Are you interested in Sunglasses? _____Yes _____No
Are you interested in Contact Lenses? _____ Yes _____No

HIPAA Privacy Policy

- I acknowledge that I have reviewed/received a copy of the **NOTICE OF PRIVACY PRACTICES.**

Lifetime Insurance Authorization and Patient Responsibility

- I request that payment of authorized insurance benefits (including Medicare benefits) for any services furnished to me or my dependent be made on my behalf to Treasure Valley Eyecare.
- I authorize any holder of medical information about me or my dependent to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.
- Services are rendered and charged to the patient, not the insurance company. We will file a claim for you, but we cannot accept responsibility for collecting on the claim or negotiating a settlement on a disputed claim. Insurance balances aged 60 days will be your responsibility.

Patient or Guardian Signature _____ **Date**_____

Print Name: _____ **Relationship** _____