Welcome To Our Office

JESSIE L. LIU, O.D.

Vision Source™

1098 Alder Ave
Marysville, WA 98270
(360) 659-6255

Patient Name: _______________________________ Male / Female Marital Status __________________

Spouse Name: _______________________________ Parent (if minor) ________________________________

Address: ___________________________________ City ________________State_____Zip Code ________

Date of Birth: _________________ Patient SS# ___________________ E-mail _______________________

Home Phone: ___________________ Work Phone: _________________ Cell Phone: __________________

Patient Employer ________________________ Whom may we thank for your referral ___________________

Name of Emergency Contact:______________________Phone Number:___________Relationship__________

<u>INSURANCE INFORMATION</u>:

Name of Insurance: ___________________________ Name of Policy Holder: _________________________

SS#/ID# of Policy Holder________________________ Employer of Policy Holder: ______________________

Please circle method of payment for today's professional services: Cash Debit Credit Card Insurance
*checks not accepted

<u>INSURANCE AUTHORIZATION</u>
I request that payment of authorized Insurance benefits for any services furnished me, be made on my behalf to Marysville Vision Source.

I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand that I am responsible for charges not paid or non-covered by the insurance plan.

Signed ____Date ___________

<u>Patient Authorization for Minors (only):</u>
I authorize the doctor and staff to treat my minor child for future office visits whether or not the child is accompanied by an adult.

Signed_____________________________Relationship to child_________________Date__________

Jessie L. Liu O.D.
Optometric Physician

Marysville Vision Source
1098 Alder Ave
Marysville, WA 98270
(360) 659-6255

Acknowledgement of Receipt of
Marysville Vision Source's
Notice of Health Information Practices

I understand that as part of my health care, Marysville Vision Source creates and maintains health records describing my health history, symptoms, examination with test results, diagnosis, treatment and any plans for future care and treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my case
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually rendered
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document.

I understand that Marysville Vision Source reserves the right to change their notice and practices, including prior to implementation. Changes will be posted at the clinic.

I understand I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or normal healthcare operations and that Marysville Vision Source is not required to agree to the restrictions I have requested.

☐ **I have received a copy of Marysville Vision Source's "Notice of Privacy Practices"**

______________________________________ ______________________________________
Signature of Patient or Legal Representative — Name of Minor Child

____
Date signed (or Date Refused)

☐ Reception: If patient refuses, please put your initials in box

Jessie L. Liu O.D.
Optometric Physician

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I, ______________________________ give consent to the office of Marysville Vision Source to
(print patient name)

release all personal and medical information to the following:

Name	**relation to patient**
______________________________	____________________
______________________________	____________________
______________________________	____________________
______________________________	____________________

I understand this will remain in effect until further notice from me.

______________________________ ____________________
Patient Signature **Date**

APPOINTMENT CANCELLATION POLICY

Marysville Vision Source

Cancellation of Scheduled appointment at least 24 hours *prior* to appointment time:	**NO CHARGE**
Cancellation of scheduled appointment within 24 hrs. of appointment time:	**$75 FEE**

Unavoidable circumstances may warrant special consideration, but please note that the above charges will apply to most cancellations. The call that you receive to remind you of your visit is a courtesy call, and should not be relied upon to remember your appointment. It is your responsibility to know when your appointment is scheduled. Thank you for understanding the importance of keeping your appoinements.

To cancel or reschedule an appointment, please call 360-659-6255. Calls left on the voice mail will be logged at the time they came in.

I understand that I will be charged the above fees if I miss my appointment or cancel in 24 hours or less. I understand this charge is not covered by my insurance.

Signature ____ Date ________________________