Vision One Inc.

ANNUAL CONFIRMATION OF PATIENT INFORMATION

Date

Name (Last, first, middle initial)

Social Security # or Patient ID

Street address, City, ST, ZIP Code

Primary phone number | Other phone number

Email address

I give Vision One Inc. permission to share my PHI with the following person(s):

Name/Relationship

Phone

Name/Relationship

Phone

Signature

Date

Has there been any change in your insurance OR medications since your last visit? Y/N

If yes, please list the new insurance information and ID numbers or medications on the line below:

I have reviewed the Notice of Privacy Practices.

Patient signature

Date

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Vision One Inc. or insurance company to release any information required to process my claims.

Patient signature

Date