Insights PA

3260 Kimball Avenue
Manhattan, KS 66503
www.insightseyecare.net

Dr. Jeanne Klopfenstein
OD, ABO, FAAO

Phone: 785-776-2255
Fax: 785-776-2266
Insights3246@gmail.com

Today's Date: ____/____/_____

Patient Name: _____ DOB: _____

Address: _____City, State, Zip: _____

Phone #1: _____ □ Cell □ Work □ Home

Phone #2: _____ □ Cell □ Work □ Home

Employer: _____Occupation: _____

NOTE: ***By providing your cell phone number, you agree to allow Insights, PA and its affiliates (such as collections agencies or billing representatives) to contact you on your cell phone.***

Ethnicity:
□ Hispanic □ Not Hispanic □ Prefer not to answer

Race: choose ANY that apply
□ American Indian or Alaska Native □ Caucasian/White
□ African American □ Asian
□ Native Hawaiian or Other Pacific Islander □ Other/Prefer not to answer

Primary Care Physician *(include practice name and location):*

_____

Pharmacy *(name and location):*

_____

Specialist *(include practice name and location):*

_____

Security and confidentiality regulations require that we have your specific preferences regarding how we may share your personal information. Please list the names and phone numbers of anyone we may relay personal medical and/or account information to.

Name	Relationship	Phone Number

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Financial Policy:

1. Payment is due at the time of service. The adult accompanying a minor to Insights, P.A. is responsible for copays required on that day of service. Insights, P.A. cannot be involved in divorce settlements and/or custody disputes. Please arrange for payment of copays when scheduling your child's appointment.
2. Verification of your insurance benefits by Insights, P.A. is not a guarantee of payment. If your insurance company denies payment for any service, you are responsible for the balance.
3. Insights, P.A. will charge a $35 fee for any check returned due to insufficient funds. The responsible party is liable for the $35 fee plus the unpaid balance.
4. Vision plans are strictly for well eye exams and do not apply if you have been diagnosed with a medical eye condition or complaints that might lead to a medical diagnosis.

Person financially responsible if patient under age 18: _____

Insurance Policyholder Name and Address (if other than self):

_____

Policyholder DOB: _____/_____/_____

Relationship to Patient: □ Spouse □ Parent □ Other_____

Preferred method for appointment reminders (*Check all that apply)*

□ Phone Call □ Text Message □ Email_____

Preferred method for all other communications (*Choose one)*

□ Phone Call □ Text Message □ Email_____

FOR NEW PATIENTS: How were you referred to our office?

□ Coworker □ Friend/Relative □ Online search engine □ Website □ Phone book

□ Other

Who may we thank for referring you? _____

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HIPAA

Insights, P.A. makes every effort to inform you of your rights related to your personal health information. You may request a copy of our privacy practices at any time. By signing below, you acknowledge that:

- ☐ I have read or had explained to me Insights, P.A.'s Notice of Privacy Practice and agree to continue my care with Insights, P.A. under said terms.
- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the office visit.

PATIENT PORTAL

- ☐ I hereby give Insights, P.A. permission to register a patient portal account for me with a unique Username and temporary Password. I agree to change the password on my first login.
- ☐ I **DO NOT** give Insights, P.A. permission to register my patient portal account. I would like to register myself and choose my own unique Username and Password.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Patient Signature Date

_____ _____

Representative Signature Relationship to Patient

Rev 01.01.2017