**MARSTON OPTOMETRY**

SHEA FERREE CARNEY, O.D.
CAROL MARSTON-FOUCHER, O.D., F.A.A.O

## WELCOME TO OUR OFFICE!

Mr./Ms./Mrs./Miss/Dr. ______________________ Date ____________
LAST FIRST M.I.

ADDRESS ______________________

CITY ____________ STATE ____________ ZIP CODE ____________

HOME PHONE ____________ BUSINESS PHONE ____________ CELL ____________

EMAIL ______________________

SOCIAL SECURITY NO. ____________ BIRTHDATE ____________

•••IF YOU ARE A NEW PATIENT TO OUR OFFICE, MAY WE ASK WHO REFERRED YOU TO US SO THAT WE MAY THANK THEM? ______________________

WHO IS YOUR GENERAL PHYSICIAN (FAMILY DOCTOR)? ______________________

WHAT IS YOUR OCCUPATION (OR GRADE IN SCHOOL)? ______________________

PERSON RESPONSIBLE FOR THIS ACCOUNT ______________________
LAST FIRST M.I.

ADDRESS (if different) ______________________

HOME PHONE ____________ BUSINESS PHONE ____________ BIRTHDATE ____________

EMPLOYER ____________ SOCIAL SECURITY NO. ____________

VISION CARRIER INSURANCE ______________________

MAJOR MEDICAL INSURANCE CARRIER ______________________

### AUTHORIZATION/RESPONSIBILITY AGREEMENT

Payment is expected at the time professional services are rendered. A 50% deposit is required before materials are ordered; balance is due upon delivery of materials.

I have requested Marston Optometry to bill my insurance company for covered services on my behalf. I clearly understand that it is still my responsibility to make sure that the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill.

I hereby authorize any insurance company to pay the proceeds of any of my benefits due me directly to Marston Optometry a copy of this can be considered as an original for insurance purposes.

Signed ______________________ Date ____________

In order to process a claim for benefits, I authorize Marston Optometry or my insurance company to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under any plan providing benefits or services. I certify that the information provided by me in support of claims is true and correct. A photocopy of this authorization shall be considered as effective and valid as the original.

Signed ______________________ Date ____________

*THANK YOU!*