

TODAY'S DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

**PATIENT INFORMATION**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Preferred Phone: (\_\_\_\_) \_\_\_\_\_  
 Home  
 Cell  
 Work

Alternate Phone: (\_\_\_\_) \_\_\_\_\_  
 Home  
 Cell  
 Work

Alternate Phone: (\_\_\_\_) \_\_\_\_\_  
 Home  
 Cell  
 Work

Social Security Number: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Material Status:

Married  Single

Divorced  Widowed

Preferred Language:

English  Other: \_\_\_\_\_

Ethnicity:

Not Hispanic or Latino

Hispanic or Latino

Unknown

Race:

White  Black or African American

Asian  American Indian or Alaskan Native

Native Hawaiian or Other Pacific Islander

Other

**PATIENT'S EMPLOYMENT INFORMATION**

Employer's Name: \_\_\_\_\_

Employed  Retired

Employer's Phone: (\_\_\_\_) \_\_\_\_\_

Student/Child  Unemployed

Occupation: \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

Insurance Company Name: \_\_\_\_\_

ID#: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Subscriber's SS#: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Insurance Company Name: \_\_\_\_\_

ID#: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Subscriber's SS#: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_

\*\*\* PLEASE BRING INSURANCE CARDS AND DRIVER'S LICENSE TO FRONT DESK \*\*\*

**PRIMARY INSURANCE INFORMATION**

Referring Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

**Financial Policy Statement**

Welcome to Kensington Ophthalmology, we are pleased you have chosen our practice for your medical care. We are committed to providing you with the highest quality services available. Please read and sign the following policy. If we are contracted with your insurance company, we will accept assignment. **All co-pays, co-insurance and deductibles are due and payable at time of service. Failure to provide necessary referrals or current accurate billing information will result in all charges for services being the sole responsibility of the patient/responsible party.** You are expected to understand your benefits coverage and financial responsibility. If we do not have a contractual obligation with your insurance company, you are responsible for 100% of the payment at time of service. You will be responsible for any balances not covered by your insurance. A return check fee of \$25 will be assessed if your check is returned by your bank.

Patient/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

**Holly S. Holm, M.D.**  
**Michelle M. Verplanck, D.O.**  
**Lesley E. Beebe, O.D.**

**[www.drhollyholm.com](http://www.drhollyholm.com)**

**PLEASE READ THIS FORM CAREFULLY**

I consent to medical care and treatments.

I authorize the release of all medical records to my physicians and insurance company. I also authorize fax transmittal of my records to my physicians and insurance company.

It is my responsibility as a patient to know my individual coverage. If my insurance company requires a referral form and I do not obtain one, I will be responsible for the bill. All referral forms are the responsibility of the patient to obtain.

I understand that payment of charges incurred is due at the time of service (deductibles, copays and non-covered services) unless other definite financial arrangements have been made prior to treatment.

I hereby authorize and request my insurance company to pay directly to Kensington Ophthalmology the amount(s) due on my claim for services rendered to my dependents or me. I further agree that should the amount be insufficient to cover the entire medical or surgical expense (deductible, copay or non-insured events), I will be responsible to the doctor for payment of the entire bill and if the bill remains unpaid for ninety days I will be responsible for all billing service fees incurred (thirty percent of the unpaid balance sent to a collection agency).

I understand that due to rising costs, that there will be a \$5.00 monthly charge for all balances 30 days past due and there is a \$25.00 fee for all checks returned for insufficient funds. I also understand if I do not come for a scheduled appointment or I do not give a 24 hour notice to cancel prior to my appointment I will be charged a fee of \$25.00

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

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Name (please print)

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Signature

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Date

**Kensington Ophthalmology  
10201 East Grand River  
Brighton MI 48116  
Phone 810-229-3363 Fax 810-229-5532**

**I authorize the following individuals to have access to my medical records:**

**PLEASE PRINT**

**Name**

**Relationship**

**Phone Number**

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**Patient Printed Name:**

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**Patient Signature:**

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**Date:**

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