Welcome to Hall Eye Care Center, L.L.C.!

In order to bill your insurance company please complete **all** of the following information:

First Name ______________________________ M.I. __________ Last Name ______________________________

Preferred Name_____________________ Birthdate _____ / _____ / _____ Social Security # _____ / _____/ ________

Parents'/Guardian's Name (If Child) ____

Home Address ____

City ______________________________ State __________ Zip Code _______________

Home Telephone (_____) _________________________ Daytime Telephone (_____) ___________________________

Cell Phone (_____) ______________________________

E-mail address: ____

Preferred Language: English Spanish

Race: White Black or African American Hispanic Asian American Indian Other/Pacific Islander

Occupation _________________________ Employer ____

1. If you have **vision** insurance, please present your **vision** insurance card.
2. If you have **health** insurance, please present your **health** insurance card.
3. Do you have secondary health or vision insurance? Yes No If yes, please present this insurance card also.
4. What is your marital status? Single Married Divorced Legally Separated Widowed Partnered

Please answer the following questions **only if you are NOT the primary insured.**

5. What is your relationship to the insured member? Spouse Child Other___________
6. Insured's Full Name ____

   Social Security #: _____ / _____/ ________ Birthdate: _____ / _____ / _____
7. Insured's Employer ____

Unless we are a participating provider for your insurance plan,
payment is expected at the time of your exam.
Verifying eligibility does not guarantee payment from your insurance company.
Payment in full is required for all materials (glasses and contact lenses)
before they leave the office.

I understand that I am responsible for paying my co-payment and any non-covered services and material fees today. If for any reason my insurance company denies payment, the total fee for service and materials is my responsibility.

Signature ____ Date _________________

(Parent or Guardian, If Child)

HALL EYE CARE CENTER, L.L.C.
ALLISON N. HALL, O.D.
#1 COLONIAL SQUARE
CLARKSVILLE, ARKANSAS 72830
(479) 705-2022

HIPAA – Patient Acknowledgement Form

I, ____________________________, hereby acknowledge receipt of Hall Eye Care Center's Notice of
(Patient's Name)

Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I authorize release of any medical information necessary to process insurance claims and payment of medical benefits directly to Dr. Hall/Hall Eye Care Center.

I understand that Dr. Hall/Hall Eye Care Center will not discuss my medical information, dispense prescriptions, glasses, or contacts to anyone without my consent.

I authorize Dr. Hall to release my protected health information and to dispense contacts or glasses to:

Only Myself ________________

Doctor: __________________Phone:____________ Doctor: ________________________Phone:___________

Name: __________________________ Relationship: _________________ Phone: ______________________

Name: __________________________ Relationship: __________________Phone:______________________

Note: Anyone who is not listed above will not be able to pick up prescriptions, glasses, or contacts. This includes a spouse or a family member who is not listed above.

Signed: ___________________________________ Date: _____________________

If you are not the patient, please specify your relationship to the patient ___________________.