Adel Vision Clinic

Dr. Lucas Bell

Dr. Barbara Scheetz

Welcome to our practice.

Thank you for selecting this office for your eye care needs.
Please provide us with the following information so we can serve you more efficiently.

Name: Last_____First_____MI___Date of Birth_____M___F_____

Minor__Single___Married___Other___Preferred Pharmacy_____Primary Care Provider_____

Mailing Address_____City_____State____Zip_____

Home Phone_____Cell_____Is it ok to text?Yes_____No_____

Employer_____Occupation_____Work Phone_____

Email_____How did you hear about us?_____

_____

Person responsible for account_____Relationship to patient_____

Date of Birth_____Last four of SS#_____Address_____

City_____State_____Zip_____Responsible party employer_____Work #_____

Emergency Contact_____Relationship_____ Phone#_____

Primary Insurance

Insured Name_____Relationship to patient_____

Date of Birth_____Insurance Company_____

Subscriber ID#_____Group #_____Last four of SSN_____

Addition Insurance (if applicable)

Insured Name_____Relationship to patient_____

Date of Birth_____Insurance Company_____

Subscriber ID#_____Group #_____Last four of SSN_____

I hereby authorize payment of benefits to the above doctors for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.
I authorize the above doctors to release my information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
I understand that I am responsible for any and all collection fees and interest charges due to my failure to pay.
If you are concerned that we may have violated your privacy rights in any way, you may complain to us using the contact information listed at the end of this notice. You may also submit a written complaint to the US Department of Health and Human Services.
Contact Person: Julia Green Telephone: 515-207-7400 Fax: 515-478-1076 Email: jgreen@adelvisionclinic.com

Signature of Responsible Party_____Date_____