Adult Registration Form

Gabrielle Family Vision Care 11411 NE 124th St., Bldg A, Ste 118 Kirkland, WA 98034 Ph 425.820.2143 Fax 425.820.2006
www.gabriellevision.com clinic@gabriellevision.com

Name (LAST, First) _____ ❑ _____ ❑ Female ❑ Male

Birthday (Month/Day/Year) _____ ❑ Preferred Pronouns _____

Street Address City State Zip

Patient's Home Number Patient's Cell Number

Employer Occupation

Patient's Work Number Patient's Email Contact

Spouse's Name Spouse's Email Contact

Spouse's Work Number

Who referred you to our office today?

Name: _____ ❑ MD/ND ❑ OT ❑ PT ❑ SLP ❑ Friend ❑ Family

Other: ❑ Insurance ❑ Advertisement (type)_____ ❑ Web Search ❑ Other

Primary Care Physician Information

Physician Name Phone Number

Clinic Name

Street Address City State Zip

Do you authorize for us to correspond with your PCP to coordinate care? ❑ YES ❑ NO

Emergency Contact Information

Name: Relationship Phone #

I hereby give Gabrielle Family Vision Care permission for my evaluation and treatment. I understand that all GFVC doctors are non-contract providers for all insurance plans and the amount due for the visit is my responsibility. GFVC is non-contracted with all insurances, so GFVC declines any payment directly to the doctor/clinic for any benefits available as a non-contract provider under my insurance plan. I understand GFVC will not bill my insurance. I understand that GFVC cannot communicate with my insurance company. I understand that it is my responsibility to obtain any referrals from my PCP as outlined by my insurance policy. I understand it is my responsibility to ask for any preauthorization as outlined by my insurance policy and I understand that it is my responsibility to contact my insurance company to review benefits and eligibility and process claims and authorizations. I understand the visit fee is due BEFORE the evaluation begins. I understand there are no refunds on services or equipment and all sales are final. I understand that I am financially responsible for any non-covered charges, processing fees and charges incurred by a collection agency in collecting any unpaid balances. GFVC accepts checks (returned checks are subject to returned check charge), cash (if exact amount), Visa, MasterCard, American Express, Discover Card, and debit cards. If fees are not paid at time of service, I understand I will be charged late fees, processing fees, and collection fees. For any changes with scheduled appointments, I understand that I must call or email 48 hours BEFORE the appointment (while getting a confirmed response by the clinic) to avoid a $150 late cancel/no show charge.

Who is Financially Responsible? Name: _____Signature:_____ Relation:

Signature of Patient or Responsible Party	Print Name of Patient or Responsibe Party / Relationship	Age	Date (M/D/Yr)	Staff Initials	Date