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
Neena Gabrielle, O.D., FCOVD

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 hereby authorize the release of any medical or other information necessary to help process insurance claims when needed. When applicable, I also authorize payment directly to the doctor/clinic for any benefits available as a non-contract provider under my insurance plan. For any changes with scheduled appointments, **I understand that I must call 48 hours BEFORE to avoid a $150 cancel/no show charge.** 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. **Returned checks are subject to returned check charge. For your convenience, we accept check, cash (if exact amount), Visa, MasterCard, American Express, Discover Card and debit cards. I understand that Dr. Neena Gabrielle is a non-contract provider for all insurance plans and the amount due for the visit is my responsibility**. **I understand the visit fee is due at time of service. I understand there are no refunds on services and all sales are final. I understand GFVC will not bill my insurance.** If not paid at time of service, I understand I will be charged late fees, processing fees, and collection fees. I understand that it is my responsibility to keep track of amounts needed to reach my deductible (if applicable). I understand that it is my responsiblity 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. I understand that it is my responsibility to contact my insurance company to review benefits and eligibility.

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