PATIENT INFORMATION

NAME:_____DOB:_____
First *MI* *Last*

_____
Address *City* *State* *Zip*

Note: If you would like to receive appointment reminders via text, please check the appropriate box. ☐ **OK TO TEXT** ☐ **OK TO E-MAIL**

HOME #_____CELL # _____WORK# _____

E-MAIL: _____ SSN#:_____ MARITAL STATUS: _____

EMPLOYER: _____ OCCUPATION:_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

WHO IS YOUR OPTOMETRIST?_____

INSURANCE INFORMATION **(List the subscriber information if different than above)**

PRIMARY INSURANCE: _____ SECONDARY INSURANCE_____

SUBSCRIBER NAME: _____ SUBSCRIBER NAME: _____

SSN: _____ DOB: _____ SSN: _____DOB:_____

DEMOGRAPHIC INFORMATION

ETHNICITY: __Hispanic or Latino __Not Hispanic or Latino **GENDER:** ___Male ___Female
RACE:__American Indian or Alaska Native __Asian __Black or African American __Native Hawaiian or Other Pacific Islander__White__Other

PATIENT RELEASE FORM

The doctors/staff of Advanced Vision Institute may release my medical information or answer questions about my care, either verbally or in writing, to the following: **(Please initial each appropriate answer and complete)**

_____ **Myself/Patient** (Required in case you call our office requesting record or to verify /change appointments)
(Initials)

_____ **Family Member (s)** –Name (s)- _____
(Initials)

_____ **Optometrist/Primary Care Doctor** _____
(Initials)

EMERGENCY CONTACT/PHONE #: _____

Please understand: Due to HIPAA regulations, without your consent, we cannot discuss anything about you with anyone, including confirming appointment times.

Authorization to Release and Assign Insurance Benefits: I understand that I am financially responsible to said doctor for charges. In the case of default on payment of this account, I agree to pay all collection costs, attorney fees, and court costs incurred in attempting to collect on the outstanding balance.

Office Financial Policies: Payment is expected at the time of service. This includes all co-pays, deductibles and outstanding balances. For your convenience, we offer the following methods of payments: CASH CHECK MASTERCARD VISA DISCOVER AMERICAN EXPRESS

******There is a $35.00 fee for a check returned by the bank for any reason******

Missed Appointment Policy: If you cancel your appointment without **48 hours** notice or do not keep your appointment you will be charged a **$50.00 No Show Fee**. If you cancel a surgery appointment, to include cataract surgery, any laser procedure or in-office procedure, without **48 hours** notice, or fail to keep your appointment, or have your surgery cancelled as a result of eating or drinking prior to your procedure, you will be charged a **$100.00 No Show Fee**.

Your signature below signifies your understanding, acceptance and agreement to our office policies.

_____ _____
Responsible Party Signature Date

Patient records maintained for six (6) years after last encounter (visit)