

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 NAME & 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