ADVANCED VISION CARE *"WELCOME TO OUR OFFICE"*

PATIENT INFORMATION, PLEASE FILL OUT COMPLETELY

DATE_____

NAME _____ NAME YOU LIKE TO BE CALLED _____

BIRTH DATE_____ AGE_____ GENDER ❑ MALE ❑ FEMALE ❑ OTHER

SOCIAL SECURITY # _____

ADDRESS _____ CITY_____ ZIP_____

CELL PHONE _____ HOME PHONE_____

EMAIL_____ WORK PHONE_____

EMPLOYER/
SCHOOL_____ GR. _____ OCCUPATION_____

REFERRED TO OFFICE BY _____ OR THROUGH:

❑ SIGN/LOCATION ❑ INTERNET ❑ ADVERTISING ❑ INSURANCE PLAN

OTHER FAMILY MEMBERS LIVING AT HOME:

IF CHILD, NAME OF PARENT(S)/GUARDIAN(S) _____

SPOUSE _____

CHILDREN _____

IF NOT COVERED BY INSURANCE, NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____

MEDICAL INSURANCE INFORMATION

NAME OF MEDICAL INSURANCE_____

INSURED'S NAME_____ INSURED'S BIRTHDATE _____

ADDRESS ❑ SAME AS ABOVE _____ CITY_____ _____ZIP_____

PHONE: HOME_____ WORK _____

RELATIONSHIP TO INSURED: ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER, EXPLAIN_____

_____

VISION CARE PLAN

NAME OF VISION INSURANCE _____

INSURED'S NAME_____ _____LAST 4 DIGITS OF SOCIAL SECURITY#_____

ADDRESS ❑ SAME AS ABOVE _____ CITY_____ZIP_____

PHONE: HOME_____ WORK _____

RELATIONSHIP TO INSURED: ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER, EXPLAIN_____

_____

NAME OF YOUR PRIMARY CARE PHYSICIAN _____

OFFICE LOCATION_____ PHONE _____

_____DATE_____

Signature of Patient (or parent if minor)

PLEASE TURN FORM OVER AND COMPLETE SIDE TWO

Rev 12/22

PROTECTED HEALTH INFORMATION

I authorize Advanced Vision Care to share my medical information with _____

(relationship) _____

Signature _____

MEDICARE PATIENTS ONLY: Please Read and Sign

I Request that payment of authorized Medicare benefits be made either to me or on my behalf to Advanced Vision Care for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

_____ DATE _____

Signature of Patient or Authorized Person

DO YOU HAVE SUPPLEMENT INSURANCE? ❑ YES ❑ NO

SUPPLEMENTAL INSURANCE NAME_____

PATIENT RESPONSIBILITY

If we are submitting a claim for services to your Medical Insurance:

Many medical insurance plans now have patient deductibles, copays, and coinsurance for special tests, including refractions, and office visits. **You are responsible for any charges your insurance notifies us of after your claim has been processed and/or denied. We will bill you for these charges after being notified by your insurance company. These fees are due within 30 days of billing.**

_____

Signature of Patient or Authorized Person Date

ADVANCD BENEFICIARY NOTICE (ABN) Refractive Services

Medicare and some Medicare Advantage Plans will not cover refractive services (the part of the exam that determines your prescription). If you choose not to have a refraction, there will be no prescription determined for glasses and/or contact lenses.

If you would like a refraction performed, the out-of-pocket fee today is $33. This fee is in addition to any copayments and/or deductibles determined by your insurance carrier.

- o I agree to have this service done today and will pay the $33 fee.
- o I do NOT want this service done today.

_____

Patient Signature Date