# PATIENT INFORMATION RECORD

Full Legal Name
_____Nickname_____
__

Home
Address_____
Apt.#_____

City_____State_____Z
ip Code_____
E-Mail Address
_____
__
Social Security Number_____Home Phone_____Cell
Phone_____
Date of Birth_____Age_____ Sex: Male Female
Marital Status_____
Occupation_____Employed by/or Retired
from_____
Employer's Address_____ Business
Phone_____
PRIMARY CARE DOCTOR_____
ADDRESS_____
CONTACT PERSON IN CASE OF EMERGENCY:
Name_____Phone_____Relation_____
How were you referred to this office?
_____
•
Spouses Name_____Social Security
#_____
Date of Birth_____Employer_____Business
Phone_____
Employer's
Address_____
_____
•
If the patient is a minor Parent or Guardian must complete the following information:
Parent or Guardian's Legal
Name_____
Father's Name_____ Mother's
Name_____

Father's Address_____ Mother's Address_____
SS#_____
SS#_____
Home Phone_____Work Phone_____ Home Phone_____Work Phone_____
Employer_____
Employer_____
Address_____
Address_____
**INSURANCE? Yes No (Insurance cards must be presented upon each visit)**
Were you injured at work?_____Workman's Compensation Carrier_____
**Are you enrolled in a Vision Care Plan?_____Name of Plan_____**
Identification #_____
Subscriber's Name_____Date of Birth_____
Subscriber's Employer_____
SS#_____

***PRIMARY INSURANCE NAME*_____Identification #_____**
**Subscriber'sName_____SS#_____**
**Date of Birth_____Employer_____**

**Secondary Insurance Name_____ Identification #_____**
**Subscriber's Name if different_____SS#_____**
**Date of Birth_____**
**Employer_____**

**I have been offered a copy of the NOTICE OF PRIVACY PRACTICES and the opportunity to review the notice.**
**I hereby authorize Advanced Vision Associates, LLC to treat my dependents or myself. I, the patient/guardian am responsible for all fees, regardless of insurance coverage.**
I hereby authorize Advanced Vision Associates, LLC to furnish information to Insurance Carriers

concerning my/their illness and treatments. This Authorization is valid as long as the above is a patient of Advanced Vision Associates, LLC. I understand that I am responsible for all financial obligations of health services and optical products for the above patient, and for reimbursement and payment of claims from my insurance company. **A late fee will be assessed on all delinquent accounts.** If for any reason this account should become delinquent and is turned to a third party for collections, I agree to pay for all rebilling charges, collection charges of **33 1/3% of the unpaid principal balance due at the time of the assignment. I further agree to pay reasonable attorney fees, court costs, interest, late fees and sheriff's fees. I understand and agree to the above terms.**

**Signature of Patient or Responsible Party_____Date_____**

**(over)**

## CONSENT TO RELEASE INFORMATION TO FAMILY MEMBER OR FRIEND

**Please list any family member or friend that you will allow us to talk to about you medical condition/ Insurance information / billing statements.**

**Name_____**
**Relationship_____**
**Name_____**
**Relationship_____**
**Name_____**
**Relationship_____**

**Patient/Representative's Signature_____**

## MEDICARE PATIENTS

As Medicare participating providers, Advanced Vision Associates, LLC will accept assignment on your insurance claims. Your signature is needed below so that we may file your insurance accordingly.

_____

_____

Name of Beneficiary Medicare Number

I request that payment of authorized Medicare benefits be made to me or on my behalf to **Advanced Vision Associates, LLC** for any services furnished to me by that Provider. I authorize any holder of medical information about me to release to the Health Care Finance Administration and it's agents any information needed to determine these benefits or the benefits payable for related services.

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_____

Patient/Representative's Signature Date

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## MEDIGAP BENEFITS

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_____

Name of Beneficiary Medigap Policy Number

I request that payment of authorized Medicare benefits be made either to me or to **Advanced Vision Associates, LLC** on my behalf for any services rendered to me by that provider. I authorize any holder of medical information about me to release to the (Medigap Insurance Name)_____ any information to determine these benefits or the benefits payable for related services.

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Patient/Representative's Signature Date

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## MEDICAID PATIENTS

I verify that I or my dependent is eligible to obtain Medicaid benefits at the time of my examination. If it is determined that I or my dependent was not eligible at the time services were rendered I agree to pay for the service in full. **Medicaid Eye Exam and Glasses Guidelines are as follows...**

**Eye exam** remain
18 yrs and under - eligible every year
19 yrs and over - eligible every 2 years

**2011-glasses eligibility**
20 yrs and under glasses – every 2 years
21 yrs and older glasses – every 5 years

_____

_____

Patient (or Guardian) Signature Date