FAMILY VISION CARE

PATIENT INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH:** _____/_____/_____ **AGE:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:**_____

HOME: _____ **CELL:** _____ **WORK:** _____

MESSAGES: [ ] CALL [ ] TEXT [ ]EMAIL LAST FOUR SS#: _____ **REFERRED BY:** _____

EMAIL: _____ **CURRENTLY IN: GLASSES CONTACTS**

PHARMACY: _____ **ADDRESS:** _____

FAMILY DOCTOR: _____ **PHONE:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

HIPAA RELEASE OF INFORMATION * ACKNOWLEDGEMENTS * MEDICAL INSURANCE POLICY

I AUTHORIZE THE RELEASE OF INFORMATION INCLUDING DIAGNOSIS, RECORDS, EXAMINATION RENDERED TO ME.
I AUTHORIZE THE RELEASE OF FINANCIAL INFORMATION REGARDING MY ACCOUNT.
THIS RELEASE OF INFORMATION WILL REMAIN IN EFFECT UNTIL TERMINATED BY ME IN WRITING. THIS INFORMATION MAY BE RELEASED TO:

* HIPAA RELEASE OF INFORMATION *

NAME: _____ **RELATIONSHIP:** _____

NAME: _____ **RELATIONSHIP:** _____

PATIENT or GUARDIAN SIGNATURE: _____ **DATE:** _____/_____/_____

* PRIVACY NOTICE *

THIS PRACTICE IS CONCERNED ABOUT THE PRIVACY OF OUR PATIENTS' HEALTHCARE INFORMATION. OUR INTENT IS TO MAKE YOU AWARE OF THE POSSIBLE USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION AND YOUR PRIVACY RIGHTS. THE DELIVERY OF YOUR HEALTHCARE SERVICES WILL IN NO WAY BE CONDITIONED UPON YOUR SIGNED ACKNOWLEDGEMENT. IF YOU DECLINE TO PROVIDE A SIGNED ACKNOWLEDGEMENT, WE WILL CONTINUE TO PROVIDE YOUR TREATMENT AND WILL USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS WHEN NECESSARY.

I ACKNOWLEDGE I HAVE BEEN OFFERED THE PRIVACY POLICY BY VISITING *www.familyvisioncarepa.com/privacy-policy*

PATIENT or GUARDIAN SIGNATURE: _____**DATE:** _____/_____/_____

* MEDICAL INSURANCE *

AS PART OF OUR SERVICES AT THIS PRATICE, WE ARE HAPPY TO ASSIST PATIENTS IN DETERMINING THE BENEFITS OF YOUR INDIVIDUAL POLICY AND IN COLLECTING YOUR REIMBURSEMENT OF INSURANCE BENEFITS FOR MEDICAL SERVICES. TO AVOID ANY MISUNDERSTANDINGS, PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

1.) THE LEGAL OBLIGATIONS OF YOUR INSURANCE PROVIDER IS BETWEEN YOURSELF AND YOUR PROVIDER, NOT BETWEEN THIS PRACTICE AND YOUR PROVIDER.
2.) WHEN YOUR INSURANCE PROVIDER(S) HAVE SETTLED YOUR PLAN'S COVERED ITEMS, YOU WILL BE NOTIFIED BY A MONTHLY STATEMENT IF THERE WERE ANY UNPAID BALANCES. UNPAID BALANCES CAN INCLUDE NON-COVERED ITEMS OR SERVICES, CO-PAYS, DEDUCTIBLES, LAPSES, INELIGIBILITY OR TERMINATION OF COVERAGES. UNPAID BALANCES ARE THE SOLE RESPONSIBILITY OF THE PATIENT.
3.) TO KEEP THE COST OF RECORDS AND COLLECTIONS DOWN, ANY PATIENT PORTION AMOUNTS ON YOUR ORDER WILL BE DUE AT THE TIME OF SERVICE.
4.) I AUTHORIZE THE USE OF THIS FORM ON ALL INSURANCE SUBMISSIONS AS WELL AS AUTHORIZING THE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANIES AS WELL AS ALLOWING THE DOCTOR TO ACT AS MY AGENT TO HELP ME IN OBTAINING PAYMENT FROM MY INSURANCE COMPANIES.
5.) I AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO THE DOCTOR AND PERMIT A COPY OF THIS AUTHRIZATION TO BE USED IN PLACE OF THE ORIGINAL.

I CONSENT AND ACKNOWLEDGE TO BILL MY MEDICAL INSURANCE POLICY DEEMED NECESSARY BY FAMILY VISION CARE

PATIENT or GUARDIAN SIGNATURE: _____ **DATE:** _____/_____/_____