CHART _____ PHYSICIAN _____

PATIENT INFORMATION

PATIENT NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____

ZIP CODE: _____ CITY: _____ STATE: _____ E-MAIL _____

HOME PHONE #: (____) _____ WORK PHONE #: (____) _____

DATE OF BIRTH: ____/____/____ SOCIAL SECURITY NUMBER: _____

MARITAL STATUS: (CIRCLE ONE) SINGLE MARRIED DIVORCED WIDOWED OTHER

PATIENT RELATIONSHIP TO RESPONSIBLE PARTY: SELF SPOUSE CHILD OTHER SEX: MALE / FEMALE

PRIMARY CARE PHYSICIAN: _____ WHO IS YOUR OPTOMETRIST? _____

REFERRED BY: _____(OD / MD) RADIO TV NEWSPAPER MAGAZINE FRIEND FAMILY EMPLOYEE

PATIENT'S EMPLOYER INFORMATION: COMPANY: _____ CITY: _____

FULL TIME / PART TIME SUPERVISOR: _____ PHONE #: (____) _____

ACCIDENT INFORMATION: DATE OF ACCIDENT: WORK RELATED? AUTO: OTHER:

RESPONSIBLE (OR INSURED) PARTY INFORMATION

RESPONSIBLE PARTY NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____ _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____ SEX: MALE / FEMALE

HOME PHONE #: ____(____) _____ WORK PHONE #: (____)_____ E-MAIL: _____

RESP. PARTYS EMPLOYER INFORMATION: COMPANY: _____ CITY: _____

SUPERVISOR: _____ PHONE #: (____) _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

ADDRESS: _____ PHONE #: (____) _____

CONTRACT (ID #) NUMBER: _____ SUBSCRIBER'S NAME: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (CIRCLE ONE) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP NUMBER: _____

CO-PAYMENT AMOUNT: $ _____ INSURED'S DATE OF BIRTH: _____

SECONDARY INSURANCE COMPANY: _____

ADDRESS: _____ PHONE #: _____

CONTRACT (ID #) NUMBER: _____ SUBSCRIBER'S NAME: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: (CIRCLE ONE) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ GROUP NUMBER: _____

CO-PAYMENT AMOUNT: $ _____ INSURED'S DATE OF BIRTH: _____

PLEASE COMPLETE THIS FORM AND BRING IT WITH YOU.

WE APPRECIATE THE OPPORTUNITY OF SERVING YOU. WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE.

INSURANCE POLICY:

Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you, we will provide an itemized statement that you may send to your insurance company for payment. We will be happy to submit to most insurance carriers if you have provided us with policy numbers, address, place of employment and any other pertinent information. You are responsible for all deductibles and charges not covered by insurance. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations: this is your responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the Doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following procedures: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any person or organization without further authorization signed by me for release of the information.

TERMS AND CONDITIONS

Customer agrees to pay a finance charge of one and one-half percent (1 ½%) per month on all amounts due and owing to Hoopes-Alldredge Vision Institute.

ATTORNEY'S FEES AND COSTS: If any legal action is necessary to enforce the terms of this Agreement, or if it is necessary to employ the services of an attorney to enforce the terms of this Agreement, the party in default or in breach hereof agrees to pay the other party's reasonable attorney's fees and court costs in addition to any other relief to which it may be entitled if Customer fails to pay any amounts owing hereunder when due, or otherwise breaches any terms of this Agreement. Customer agrees to pay up to a 40% collection expense incurred by Hoopes-Alldredge Vision Institute in attempting to collect such amounts from Customer, in addition to the aforementioned attorney's fees and cost.

SIGNED: _____ **DATE:** _____

Patient, Parent or Guardian

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME: _____

PHONE #: _____

RELATIONSHIP: _____

ADDRESS: _____

NOTICE OF PRIVACY PRACTICES

I, _____acknowledge that I have received a copy of Hoopes-Alldredge Vision Institute "Notice of Privacy Practices". This Notice describes how Hoopes-Alldredge Vision Institute may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____

Signature of Patient, or Personal Representative Date

Relationship to Patient _____

Internal Use Only

If Patient/Patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____