TOTALVISION EYE HEALTH CENTER, LLC

Patient Information

Last Name _____ First Name _____ ❒ Male ❒ Female

Social Security # _____ Birth Date _____/_____/_____

Patient Employer Information

Employer Name _____ Employer Phone # (_____)_____

Employer Address _____
Street City State Zip

Occupation _____ If student ❒ Full time ❒ Part time

School_____

Insurance Information

Do you have health insurance? Yes ❒ No ❒ Vision Insurance? Yes ❒ No ❒ ONLY list if we do not have a copy of your card.

Insurance _____ Copay $ _____ I.D. # _____

Subscriber ❒ Self If other: Name _____ Relationship _____

Spouse's or Parents Information (If patient is covered by spouse or parents insurance)

Name _____ Birth Date _____/_____/_____ SS# _____

Employer _____ Employer's Phone (_____)_____

Employer Address _____
Street City State Zip

Emergency Information: List nearest relative, preferably not living with you

In case of an emergency, we may contact: (_____)_____ _____
Telephone Number Relationship to patient

Authorization for Treatment, Payment & Healthcare

I authorize the release of my medical information for purposes of treatment, payment, and healthcare operations. All payments are required in full at the time of services, and before any materials can be ordered. *Please note that contact lens wearers will be charged a contact lens fitting in addition to any other charges on a yearly basis. A $25.00 fee will be charged for all returned checks.*

Additionally, I authorize and assign any payment of medical benefits to TotalVision Eye Health Center, LLC, its successors and assigns, or any individual it may designate for services provided.
As part of this authorization, TotalVision Eye Health Center, LLC will release HIV, Drug and Alcohol, and Mental Health/Psychiatric information as required by law.

Signature of Patient or Parent of Minor Date

Medicare Authorization for Treatment, Payment & Healthcare Operations. Medicare Recipients Sign both Authorizations

I authorize the release of my medical information for purposes of treatment, payment, and healthcare operations. I request that payment of Authorized Medicare benefits be made on my behalf to TotalVision Eye Health Center, LLC for services furnished to me by the providers. I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits for related services rendered.

Signature of Patient Date

I understand that I am financially responsible for payment in full for optometry services and materials provided by this office and that a finance charge of 1.5% per month, 18% APR will be assessed on any past due balance. I understand that after 90 days my account will be considered delinquent and I will be responsible for paying collection costs per applicable state law along with any court costs and reasonable attorney fees pertaining to the collection of the account.

Signature_____ Date_____

Notice of Privacy: ❒ Received ❒ Refused

_____
Signature of Patient or Parent of Minor Date

May release protected health information to: _____
Name Relationship