PeposeVision
INSTITUTE
www.peposevision.com

# RETURNING PATIENT INFORMATION FORM

**LAST NAME*:** _____ **FIRST NAME*:** _____ **MI*:** _____

**DATE OF BIRTH*:** _____ **AGE**: ____ **SEX***: ☐ Male ☐ Female **SOCIAL SECURITY#**: _____

**ADDRESS**: _____ **HOME PHONE #:** _____
_____ **CELLPHONE #:** _____
_____ **EMAIL**: _____

**MARITAL STATUS:** ☐ Married ☐ Divorced ☐ Widowed ☐ Single

**RACE*:** ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ African American
☐ Asian ☐ American Indian ☐ Other: _____

**ETHNICITY***: ☐ Hispanic/Latino ☐ Other

**PRIMARY CARE PHYSICIAN:**_____ **PHONE #**_____
**ADDRESS:**_____

**PHARMACY NAME*:** _____ **PHARMACY #:** _____

**Do you smoke?*** ☐**Current every day** ☐ **Current some days**
☐ **Former: from**_____ **to** _____ ☐ **Never** ☐ **Unknown**

**Do you drink alcohol?** ☐ **Yes** ☐**No** **If yes, how much?** _____

**Do you have allergies?*** ☐ **Yes** ☐**No**
If yes, explain: _____

**Are you taking any medications?*** ☐ **Yes** ☐**No**
If yes, explain: _____

## Authorization to Release Medical Information:

I hereby authorize the physician, PVI to release any information from Patient Medical Records required in the course of my examination and treatment to any insurance company against which claims are filed for me or my dependents.

I am aware of my rights to privacy of personal health information under the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Occasionally you may be contacted by our affiliated nonprofit Foundation (Lifelong Vision Foundation) to inform you of (i) new clinical studies that may be appropriate for your specific vision condition; or (ii) new community-based outreach programs that you may wish to support as a volunteer or donor. Should you wish to opt out of these communications please initial here. _____

I understand payment for all office services is expected at the time of my visit, unless other arrangements have been made prior to my visit. I hereby authorize payments to be made directly to PVI for all sums due for services rendered. Any past due balance sent to an attorney or collection agency is the responsibility of the guarantor and he/she agrees to pay ALL collection fees and court costs.

_____ _____ _____
Patient or Guardian Signature Relationship Date

**Date:** _____ **Staff Initial:** _____

**OVER** ⇨

# PEPOSE VISION INSTITUTE FINANCIAL POLICIES

We are glad you have chosen us for your vision care. Full payment for all services provided is expected on the day of your visit unless you have health insurance coverage with a plan with which we have a written agreement **and** the service is a covered service under your plan. Your insurance provider **requires us to collect all applicable deductibles and copayments at the time that any medical service is provided**. Such payments, as well as payments for noncovered services, may be paid by cash, check (under $200) or credit card (Visa, MasterCard, Discover). There is a fee of $25 for any checks returned by the bank.

We must have a copy of the front and back of your insurance card(s) along with your driver's license or other photo ID at your initial visit. You may be asked to provide your insurance card at subsequent visits. We will require the name, date of birth, address, telephone number and employer of the family member through whom you are insured. You are responsible for notifying us (1) of any change in address, telephone number, employer or insurance coverage; and (2) whether your insurance coverage requires a referral to our office or pre-certification for any services rendered. Should your insurance deny payment of your medical claim for either reason, you are financially responsible for any outstanding charges for services rendered.

**PATIENT INITIALS**: _____

**REFRACTION POLICY**

**A refraction is a measurement of lens power necessary to prescribe glasses or other corrective lenses. Most insurance plans, including Medicare, DO NOT cover routine refractions (when no medical eye problem is known or suspected). Insurance companies permit us to charge separately for this refraction since it is not included in your covered eye exam. Upon payment of this fee, you may request a copy of your refraction in order to purchase prescription glasses.**

**THE FEE FOR THIS SERVICE IS $69**

**PATIENT INITIALS: _____**

**AUTHORIZATION OF PAYMENT:** I hereby authorize payments to be made directly to PVI for all sums due for services rendered. Any past due balance sent to an attorney or collection agency is the responsibility of the guarantor and he/she agrees to pay all collection fees and court costs.

_____ _____

Name of Patient (Print) Signature / Date

_____ _____

Name of Responsible Party (Print)
[If not Patient] Signature/ Date