PATIENT INFORMATION FORM

Whom may we thank for referring you? ☐Family/Friend ☐ Doctor: _____ ☐ TV/Print

LAST NAME*: _____**FIRST NAME*:** _____ **MI*:** _____
DATE OF BIRTH*: _____ **AGE**: ____ **SEX***: ☐ Male ☐ Female **SOCIAL SECURITY#**: _____
ADDRESS: _____
HOME PHONE#:_____**CELL #:**_____**EMAIL**:_____
PRIMARY CARE DOCTOR: _____**PHARMACY NAME*:** _____

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**: _____

EMERGENCY CONTACT INFORMATION

NAME: _____**RELATIONSHIP**: _____**PHONE #**_____

******Please fill out the insurance information below **ONLY** if you are **NOT** the primary card holder******

PRIMARY INSURANCE: _____**SECONDARY INSURANCE**: _____

POLICY HOLDER'S INFORMATION

LAST NAME*: _____**FIRST NAME*:** _____ **MI*:** _____
DATE OF BIRTH*: _____ **AGE**: ____ **SEX***:☐ Male ☐ Female **SOCIAL SECURITY#**: _____
ADDRESS: _____
HOME PHONE#:_____**CELL #:**_____**EMAIL**:_____
EMPLOYER: _____ **OCCUPATION**:_____

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.

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

Authorization to Release Medical Information

I hereby authorize the physician, 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. _____

_____	_____	_____
Patient or Guardian Signature	Relationship	Date

PEPOSE VISION INSTITUTE, P.C.
CONSENT FOR DISCLOSURE OF PERSONAL MEDICAL INFORMATION

As a patient, I agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby authorize the physicians and staff of Pepose Vision Institute, P.C. to disclose my personal medical information to the following individual(s).

Name: _____Relation: _____Phone: _____
Name: _____Relation: _____Phone: _____
Name: _____Relation: _____Phone: _____

☐ Pepose Vision Institute, P.C. may disclose my medical information when I am not present; this includes telephone calls, fax or mail.
☐ Pepose Vision Institute, P.C. may disclose my medical information only in my presence.

I understand that consent may be revoked by me at anytime by written notice of Pepose Vision Institute, P.C.

Patient Signature: _____Date: _____

Reviewed by M.D.: _____Date: _____
COMMENTS: _____