ADVANCED VISION CARE
A MEMBER OF VISION SOURCE

WELCOME TO OUR OFFICE

Date: ____/____/____

Name: _____ Name you like to be called: _____

Date of Birth: ____/____/____ Age: _____ Gender: Female Male Non-Binary

Address: _____ Apt # _____

City: _____ State: _____ Zip _____

Cell Phone: _____ Home Phone _____

Email: _____ Occupation: _____

Employer: _____ Work Phone: _____

If minor, name of parent/guardian(s): _____

If married, name of spouse: _____

How did you hear about our office? Sign/Location Internet Insurance Plan Referred By: _____

PROTECTED HEALTH INFORMATION

I authorize Advanced Vision Care to share my medical information with:

Name:

_____ Relationship: _____

PATIENT RESPONSIBILITY

If we are submitting a claim to your vision plan or medical insurance, you may owe co-pays, co-insurance or deductibles that your insurance company notifies us of after your claim has been processed. Any amount determined by the insurance company to be your financial responsibility will be billed to you and is due within 30 days of notification.

_____ _____

Signature Date

PLEASE TURN OVER AND COMPLETE OTHER SIDE

MEDICAL INSURANCE INFORMATION - please present medical insurance card to receptionist

Name of Medical Insurance: _____

Name of policy holder: _____

Birthdate of policy holder: _____/_____/_____

Relationship to policy holder: Self Spouse Child Other, explain_____

Address/Phone, if different than patient: _____

VISION CARE PLAN INFORMATION

Name of Vision Plan: _____ ID# _____

Name of policy holder: _____

Policy holder's social security #: _____

Relationship to policy holder: Self Spouse Child Other, explain: _____

Address/Phone, if different than patient: _____

MEDICARE PATIENTS ONLY — please read and sign

I request that payment of authorized Medicare benefits be made on my behalf to Advanced Vision Care for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

_____ _____

Signature Date

Do you have Medicare Supplemental Insurance? No Yes ***If yes, please present card to receptionist

Name of Supplemental Insurance: _____

MEDICARE REFRACTIVE SERVICES--ADVANCED BENEFICIARY NOTICE (ABN)

Medicare and some Medicare Advantage Plans will not cover the refraction (the part of the exam that determines an eyeglass prescription). If you choose not to have a refraction, there will be no prescription available for glasses or contact lenses.
If you would like a refraction to be performed, the out-of-pocket fee is $38.00. This fee is in addition to any co-payments, co-insurance or deductibles determined by your insurance carrier.

_____ I agree to have a refraction performed today and will pay the $38.00 fee.

_____ I do NOT want to have this service done today

_____

Signature Date