DAVIS VISION CENTER
THE CLEAR CHOICE FOR EYES

First name: _____**Last Name:** _____ **MI:** _____

Date of Birth_____ **Age:** _____ **Sex:** ( ) **M** ( ) **F** **Marital status:** _____

Language: _____ **Race:** _____ **Ethnicity:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Cell Phone: _____ **Home:** _____ **Business:** _____

Email address: _____ **Primary Care Physician:** _____

Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

How did you hear about us?

_____

Employer: _____**Occupation:** _____

Guardian/ Responsible Party Name: _____ **Relationship:** _____

Address (If different):

_____

Primary Insurance: _____ **ID #:** _____ **Group #:** _____

Policy Holder: _____ **DOB:** _____ **Relationship:** _____

***Secondary Insurance*:** _____ **ID #:** _____ **Group #:** _____

Policy Holder: _____ **DOB:** _____ **Relationship:** _____

***Vision Insurance*:** _____ **ID #:** _____ **Group #:** _____

Policy Holder: _____ **DOB:** _____ **Relationship:** _____

Patient Authorization: Due to HIPAA regulations, we are unable to communicate with anyone regarding you without your authorization. Please list any individuals with whom we are authorized to communicate with.

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Do you authorize us to leave voicemails regarding personal medical information? ( ) Yes ( ) No

*****I have had the opportunity to read and ask about HIPAA regulations, as required by law either today or in the past. **Signature:** _____

Financial Assignment and Agreement:

As a courtesy, Davis Vision Center will file claims to my insurance carrier. If I do not have insurance, it is required that I pay at the time of service. I understand it's my responsibility to pay any co-pay, deductible or other balance not paid by my insurance. I understand co-pays and deductibles are due at the time of service, a $10.00 late fee will be added if they are billed to me. I am required to provide a valid insurance card at each visit. If my insurance requires a referral, it's my responsibility to acquire or I will not be seen. I agree if balances are not paid after 90 days they will be sent to collections for non-payment with a collections fee (up to 40% of balance) and possible court and attorney fees and I am responsible for these costs. I agree to pay a service charge of $25 for any returned checks. I agree if I do not give 48 hours notice when cancelling or rescheduling, a $50 fee may be charged for an appointment and a $200 fee for a missed surgery. I hereby authorize release of medical information for the purpose of processing claims and I assign all applicable benefits to Davis Vision Center and/or its providers. I understand that if a medical diagnosis is found and treated during my appointment, my medical insurance will be billed rather than my vision insurance.

Signature: _____
Relationship to patient: _____
Date: _____