Welcome to Our Office

What is the main reason for your visit today? **Today's Date**_____

_____

Personal Information

Patient's Last Name _____First Name _____MI_____

Street Address_____ City_____ State_____ Zip Code_____

Date of Birth____/_____/_____ Patient's SSN_____ E-mail_____ Sex: _____

Home Phone _____ Cell Phone _____ Work Phone _____

Race: ☐African American/Black ☐American Indian ☐Alaskan Native ☐Asian ☐Hispanic/Latino ☐Pacific Islander ☐Caucasian ☐Declined ☐Other:_____

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Native Hawaiian/Other Pacific Island ☐Declined ☐Other _____

Preferred Language: ☐ English ☐ Spanish ☐Japanese ☐French ☐ Declined to Specify

Preferred communication: ☐ Telephone ☐ E-mail ☐ Postal

Messages: CHVC Dr.'s and Staff may leave detailed messages on the following numbers: ☐ Home ☐ Cell ☐ Work

CHVC Dr.'s and Staff may also leave detailed messages with:_____

Employer/School_____ Occupation/Grade_____

Spouse or Parent's Name _____

Referred by (please provide full name): _____

Patient Eye History **Date of last eye exam**_____

Do you currently wear contact lenses? _____ Do you use more than one pair of glasses? _____

Are you interested in (check all that apply): ☐Colored Contacts ☐ Extended Wear Contacts ☐ Laser Vision Correction Surgery

Medical History

Name of family physician_____ Phone_____

Do you have a history of:

☐ Diabetes	☐ Eye injury or surgery	☐ Retinal detachment	☐ Dry Eye
☐ Cataract	☐ Flashes or floaters	☐ High Blood Pressure	☐ Tobacco use
☐ Glaucoma	☐ Lazy eye or eye turns	☐ Macular Degeneration	☐ Alcohol use

List of current medications and eye drops:

_____

_____

Allergies to medications_____

_____

Insurance: The eye health portion of your examination may be billable to your medical insurance even if you do not have vision coverage.

Vision Insurance_____

Subscribers Name_____

Subscribers Date of Birth _____/_____/_____

Subscribers SSN _____

ID# _____

Employer _____

Medical Insurance_____

Subscribers Name_____

Subscribers Date of Birth _____/_____/_____

Subscribers SSN _____

ID# _____

Employer _____

Please see reverse side

Welcome to Our Office

Payment Policy

Payment is required at the time services are rendered. This includes applicable coinsurance and copayments for participating insurance companies. Acceptable forms of payment are cash, personal checks, VISA, MasterCard, and Discover. There is a $25 service charge for returned checks. A photo ID of the patient is required. If the patient is a minor, the parent/guardian will provide their ID.

All patient balances are at the time of service unless a formal payment plan is established with the clinic. A $25 per month billing fee will be assessed for any balance over 60 days.

Insurance
We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 60 days of the date of service, you will be expected to pay your balance in full.

"I understand that benefits quoted by my insurance to our staff are NOT a guarantee of payment. I will be responsible for any remaining balance that is not covered by my carrier regardless of quoted benefits."

Sign _____ Date_____

Referrals
"If I am required to have a referral or authorization for services, it is **my responsibility** to get one and maintain it as needed. I understand that if I do not get the required referral or authorization I will be responsible for any charges incurred at my visit."

Sign _____ Date_____

Missed Appointments/Late Cancellations
Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. Excessive abuse of scheduled appointments may result in discharge from the practice. A $50 fee will be charged for missed or late-cancellation appointments.

"By signing I acknowledge that I have read, understand and agree to this financial policy and authorize assignment of payment directly to Chapel Hills Vision Clinic for services provided to me. I also authorize the release of pertinent medical information to my insurance company when requested or to facilitate payment of a claim."

Sign _____ Date_____

HIPPA Acknowledgement
We respect our legal obligation to keep health information private. We are obligated by law to give you notice of our privacy practices. If you would like to receive a copy of our notice of privacy practices, please request one today with the receptionist or at any time in the future.

"I understand that Chapel Hills Vision Clinic has a notice of privacy practice which is available for my review if I wish. At the present time I acknowledge that this notice has been offered and I:

_____ Accept CHVC's notice of privacy practices
_____ Decline receiving a copy of CHVC's notice of privacy practices even though I may receive a copy at any time upon request."

Sign _____ Date_____

Our entire staff thanks you for choosing our clinic. Please let us know if you need any special accommodations.