Date: _____

Chart Number: _____

Account Number: _____

Doctor: _____

VANCE THOMPSON VISION

PATIENT INFORMATION

PATIENT NAME: _____ NAME TITLE_____ FEMALE I MALE
(LEGAL) LAST FIRST MIDDLE INITIAL

ADDRESS: _____
STREET PO BOX CITY STATE ZIP

HOME PHONE: ( )_____ CELL PHONE: _____ EMAIL: _____

MARITAL STATUS: ❑ MARRIED ❑ SINGLE ❑ DIVORCED ❑ WIDOWED ❑ SEPARATED

BIRTH DATE: _____ AGE:_____ SOC SEC NO:_____

EMPLOYER:_____OCCUPATION:_____WORK PHONE: ( ) _ EXT: _____

PATIENT'S ALTERNATE NAME (NICK NAMES/MAIDEN NAMES): _____

SPOUSE'S NAME: _____ BIRTH DATE: _____ SOC SEC NO: _____

EMPLOYER: _____OCCUPATION: _____ WORK PHONE:_____ EXT: _____

IF PATIENT IS A MINOR

RESPONSIBLE PARTY / BILLING INFORMATION:

MOTHER'S NAME:_____ BIRTH DATE:_____ SOC SEC NO: _____

ADDRESS: _____HOME PHONE: ( ) _____
STREET PO BOX CITY/STATE/ZIP

EMPLOYER: _____ WORK PHONE: (_____) _____ CELLPHONE: (_____) _____

FATHER'S NAME:_____ BIRTH DATE:_____SOC SEC NO: _____

ADDRESS: _____HOME PHONE: ( ) _____
STREET PO BOX CITY/STATE/ZIP

EMPLOYER: _____ OCCUPATION: _____

WORK PHONE: (_____) _____ CELL PHONE: (_____) _____

SIBLING: _____ BIRTH DATE:_____ SIBLING: _____BIRTH DATE: _____

SIBLING: _____ BIRTH DATE:_____ SIBLING: _____BIRTH DATE: _____

NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU

NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____
STREET PO BOX CITY STATE ZIP

HOME PHONE: (_____) _____ CELL PHONE: _____

EMPLOYER: _____ WORK PHONE: (_____) _____EXT._____

FINANCIAL RESPONSIBILITY

I agree that I am financially responsible for all charges related to services provided by Vance Thompson Vision. I also agree to abide by Vance Thompson Vision's payment guidelines, including payment of any periodic late fee. These guidelines are available for my review upon request to Vance Thompson Vision. If I have additional questions about my financial responsibility for Vance Thompson Vision's charges, I may contact the business office.

Further, if I am provided health care services by a health care provider, while a patient within a facility or entity, I am financially responsible for all charges related to services provided by my health care provider. Vance Thompson Vision billing statements will not include charges by health care providers. I agree to abide by my health care provider's payment guidelines.

ASSIGNMENT OF PAYER BENEFITS

I agree Vance Thompson Vision and my attending health care provider will bill and provide necessary health information to any Payers. "Payers" are any health care insurance, private or government health plan or insurance policy that I have or another third party that will pay the charges I have incurred. All Payers may make payments directly to Vance Thompson Vision and my attending health care provider. My signature on this form is my authorized signature for the filing of a claim and request for direct payment of benefits by any Payer to Vance Thompson Vision and my attending health care provider. I agree that unless Vance Thompson Vision or my attending health care provider have agreed with the Payer to accept payment from the Payer as full payment, I am responsible to pay any charges not paid by the Payer. These charges can include but are not limited to co-pays, deductibles, co-insurance amounts and charges for non-covered services.

MEDICARE BENEFICIARY REQUEST FOR PAYMENT AND ASSIGNMENT OF BENEFITS

If I am a Medicare beneficiary, I request that payment of authorized Medicare benefits be made on my behalf to Vance Thompson Vision and my attending health care provider for any services furnished me by Vance Thompson Vision and my attending health care provider, including physician services. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits for related services.

DISCLOSURE OF HEALTH INFORMATION

I consent to the disclosure of my health information to non-Vance Thompson Vision related health professionals or entities for treatment, billing, and other healthcare operations purposes. This consent will remain in effect unless revoked.

I agree to the sharing of medical information with my family, friends, or others as allowed by law when it reasonably appears they are directly involved with my treatment, medical decisions or payment of care. If I do not agree, I will ask for a restriction request to limit sharing of my information. The sharing of medical information with family, friends or others does not give them permission to obtain copies of my medical record.

ACKNOWLEDGEMENT

I have read the information above, and I have had the opportunity to ask questions and have them answered to my satisfaction. If I am not the patient identified in the below label on this form, I represent that I am authorized by law to agree to these conditions on the patient's behalf and am the authorized representative of the patient. A copy of this form is a effective and valid as the original.

_____ _____ _____ a.m./p.m.

Signature of Patient or Authorized Person | Date | Time

_____

Relationship to Patient (if not patient signing)