INNOVATIVE VISION

PATIENT REGISTRATION AND VERIFICATION

PATIENT INFORMATION

First Name: _____ MI: ___ Last Name: _____

Gender: ☐M ☐F Date of Birth: _____ SSN: _____ Martial Status: ☐S ☐M ☐D ☐W

Address: _____ City: _____

State: ___ Zip: _____ Home Phone: _____ Cell Phone: _____

Preferred Phone: _____ Texting: ☐Y ☐N Email: _____

Employer: _____ Occupation: _____

Whom May We Thank for Referring You? _____

INSURANCE SUBSCRIBER INFORMATION

Relationship to Insurance Holder: ☐Self ☐Spouse ☐Child ☐Other

First Name: _____ MI: ___ Last Name: _____

Date of Birth: _____ SSN: _____ Phone: _____

Address (if different from patient): _____

City: _____ State: ___ Zip: _____ Employer: _____

NOTICES AND CONSENTS

Financial Policy

Thank you for choosing Innovative Vision for your eye care needs. We are committed to providing the best care possible. Please understand that payment of your bill is considered a part of your treatment. The following statement explains our Financial Policy.

With the growing complexities and constant changes of insurance policies, it can be difficult to stay up-to-date. While we try our best to stay aware of patients' insurance policies, **the ultimate responsibility of knowing the specifics of your coverage lies with you.** It is your responsibility to understand and comply with any pre-determination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services and may not be considered medically necessary under Medicare, Medicaid, or other medical insurance companies.

All applicable co-pays and outstanding balances are due at the time of service. For checks returned to us unpaid by your bank, we will charge a $15.00 fee. Past due balances over 90-days outstanding are subject to collections.

Consent for Treatment, Release of Information and Claim Payment Authorization

I give permission to Innovative Vision to examine/treat myself and/or my dependent as they deem necessary. I hereby give consent to the attending physician to release my information acquired in the course of examination or treatment and allow a photocopy of my signature to be used for insurance purposes only. I give permission to release medical records or information to other medical doctors. The patient hereby gives consent to his/her insurance company(s) at its option to issue indemnity checks to the rendering provider.

☐ I have read, understand, and agree to these notices and consents.

Patient/Guardian Signature: _____ Date: _____