Hoover Vision Center, P.C.

PATIENT INFORMATION

(Please Print)

Date: ____/_____/_____ New _____ Update _____

Last name _____ First name _____ Middle _____

Preferred name _____ Date of Birth ____/_____/_____ Age _____ Sex: *M / F*

Social Security _____ - ___ - _____ Drivers License # _____ Marital Status: *S / M / W / D*

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Other Phone _____ Email _____

Preferred Contact*: Home Phone / Cell Phone / Work Phone / Email / Regular Mail*

Preferred Language: *English / Spanish /*_____Ethnicity: *Hispanic/Latino // Not Hispanic/Latino*

Race*: American Indian or Alaskan Native / Asian / Black or African American*

Native Hawaiian or Pacific islander / White

Occupation _____ Status: *Employed / Retired / Unemployed / Disabled*

Employer _____ If Student: Grade _____ School _____

Who referred you to this office ? _____

Please list any family members who are patients of this office.

Name	Relation	Age

Emergency Contact _____ Phone _____Relationship_____

<u>Insurance Information</u>

Primary *(medical)* _____ Policy # _____ Group #_____

Insured Name: _____ Insured DOB _____

Secondary *(medical)* _____ Policy #_____ Group # _____

Insured Name: _____ Insured DOB _____

Vision Plan_____ Policy # _____

Insured Name: _____ Insured DOB _____

Please have insurance cards and drivers license available for receptionist to copy*

Please turn this form over and complete side two*

Financial Information

Is patient responsible for bill? Yes / No If not, complete the following information:

Guarantor: Last name _____ First name _____

DOB _____/_____/_____ Social Security # _____

Address _____

Home phone _____ Work Phone _____

Employer _____ Relationship _____

Note: Minors must be accompanied by an adult for examination and when picking up materials.

Collection Policy

Our doctors participate in a variety of insurance plans. As a courtesy to our patients, we will be happy to file most claims. You will be expected to pay your co-pay, deductible, and any non-covered service at each visit. For example, refractions, which are a necessary component of an eye exam, are not covered by Medicare. *If your insurance requires a referral, it is your responsibility to contact your primary care physician and obtain the referral number and any other necessary information*. If you have any questions about your insurance or account, please feel free to contact our insurance and billing coordinator.

I authorize the release of any medical information necessary to process a claim on any insurance policy listed above. I hereby assign to and authorize payment directly to Hoover Vision Center. P. C. for all benefits payable under such insurance policy. I realize that the insurance benefits may not pay all of the bill, and I agree to pay the difference or the entire bill if necessary. In the event of default in the payment of my charges, I agree to pay all cost of collection, including a reasonable attorney's fee, should the account be referred to an attorney for collection. I further agree to waive my rights of exemption as to personal property.

I understand that a finance charge of 1.5% per month shall be added to all balances over 30 days.

I have read the above policies and agree as indicated by my signature.

_____ _____

Patient or Responsible Party Signature **Date**