ALPINE VISION

# WELCOMES YOU TO OUR OFFICE!

## Patient Information

Last Name _____

First Name _____MI_____

Date of Birth_____Age_____Sex F M

Street Name_____

City_____State_____Zip_____

Home Phone_____

Cell Phone_____

☐ Patient ☐ Spouse ☐ Parent

Patient's Email_____

Patient's Employer_____

Spouse/Parent's Name_____

Spouse/Parent's Email_____

Spouse/Parent's Employer_____

What is the major purpose of this visit?
_____

Are you currently noticing any vision changes with your eye glass prescription? _____

Do you currently wear contact lenses? Yes No
If yes, what brand?_____

******PLEASE NOTE: Fees for the contact lens fitting and evaluation of contact lenses are usually not covered by insurances and there will be a charge for these services.***

Have you had any surgeries, diseases or injuries to your eyes?_____
_____
_____

Current Medications **(Include any over-the-counter)**
☐ None ☐ I have a written List

Please list medications and **reason for taking**:
_____
_____
_____
_____
_____
_____

Allergies to Medications: YES NO
If yes, please list:_____
_____

Pregnant or nursing? YES NO

Do you have Diabetes? YES NO
Family Member_____

High blood pressure? YES NO
Family Member_____

High cholesterol? YES NO
Family Member_____

Cancer? YES NO
Family Member_____

Cataract? YES NO
Family Member_____

Glaucoma? YES NO
Family Member_____

Macular Degeneration? YES NO
Family Member_____

Other conditions not listed:_____
_____
_____
_____
_____

# Insurance Information

**Please fill out <u>BOTH</u> Vision & Medical Insurance**

**Vision Insurance**_____
Subscriber's Name_____
Subscriber's SS# or ID#_____
Subscriber's Date of Birth_____
Relation to Patient_____

**Medical Insurance**_____
Subscriber's Name_____
Subscriber's SS# or ID#_____
Subscriber's Date of Birth_____
Relation to Patient_____

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not Alpine Vision. Payment of all insurance co-pays, deductibles, and contact lens fitting or evaluation fees are required at the time of service. As a courtesy, this office will submit claims to your insurance carrier; however, the bill is your responsibility whether your insurance company pays or not. Any fees not covered by your insurance in 60 days will be billed to you.

I, the undersigned, give permission to release information to third-party carriers and do assign all insurance benefits for treatment of services to be paid directly to providers at Alpine Vision and request that this assignment remain on file with my insurance carrier. I certify that a copy of this assignment shall be as valid as the original. I recognize that the provider cannot accept responsibility for collecting any insurance claim or negotiating any settlement on a disputed claim. I also agree that in the even of default in the payment of any amount due, and if this account is placed in the hands of an agency or attorney for collection or legal action. I agree to pay the cost of collection, including agency and attorney fees and court costs incurred and permitted by laws governing the transactions. Collection costs will be up to 40% in addition to the principle balance. I also confirm that all the information on this form is true and correct to the best of my knowledge.

Signature_____

Date_____

# HIPPA Privacy Rule

The Department of Health and Human Services has established a **"Privacy Rule"** to help insure that personal health-care information is protected for privacy and to provide a standard for health-care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment or health-care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to protect and secure that privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health-care information in order to provide health care that is in your best interest.

We also want you to know we support full access to your personal medical records. We may have indirect treatment relationships with you (such as labs that only interact with doctors and not patients) and may have to disclose your personal health information for purpose of treatment, payment, or health-care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law we have the right to refuse to treat you should you choose to refuse to disclose your personal health information.

You have the right to review our privacy notice, request restrictions and revoke consent in writing. Copies of our privacy notice are available at the front desk. If you have any questions or concerns about our privacy practices, please ask to speak to our HIPPA Compliance Officer.

## <u>ACKNOWLEDGMENT OF RECEIPT</u>

I acknowledge that I received a copy of Alpine Vision Center's Notice of Privacy Practices.

Patient's Name:_____
Signature:_____Date:_____

**I authorize the release of any and all information, including diagnosis, financial and medical records and claim information to:**
Spouse_____
Child(ren) _____
Other_____

**Please do not release medical information to anyone.** ☐