THE OFFICE OF
TECH RIDGE VISION
CONFIDENTIAL PATIENT INFORMATION

Date______/______/______

PLEASE PRINT
Dr. Mr. Mrs. Ms. Miss ____ ☐ Male ☐ Female
Address: ____ City/State:_____________________ Zip: _________
Home Phone: _________________________________ Cell Phone/Pager:_______________________________
Work Phone: _________________________________ SS #:_______-_______-_________
Age: _____ Date of Birth: ______/______/______ Driver's License #:_________________
E-mail: ____
Employer: ________________________________Occupation:_________________________________
Marital Status: _______________________ Spouse's Name: ___________________________________
Spouse's Cell: __________________ Work Phone: ____________________ Employer: ____________________
In Case of Emergency, Contact: ___________________________________ Phone: _______________________
Primary Care Physician: ______________________________________ Phone:______________________
Date of Last Physical Exam: ____________________
How did you hear about us?:____

If patient is a child or adolescent, please complete the following:

Mother's Name: ___________________________________
Cell Phone: __________________ Work Phone: ____________________ Employer: ______________________
Father's Name: ____________________________________
Cell Phone: __________________ Work Phone: ____________________ Employer: ______________________
Legal Guardian's Name: _____________________________
Cell Phone: __________________ Work Phone: ____________________ Employer: ______________________

As a courtesy, we will file most primary insurance claims for you if we have the following information:

1. ***Photocopies of the front and back of your valid, insurance ID card(s).***
2. ***Authorization to file insurance claims and receive direct payment for services.***
3. ***Notification of changes in your insurance coverage, address or phone number.***

Primary Medical Insurance: ___________________________________ **Phone #:** _______________________
Name of Policy Holder: _________________________________ Relationship to Patient: ___________________
Policy Holder Date of Birth: ___________ Employer: __________________
PCP Referral Required? ☐ Yes ☐ No PCP:_________________________

Secondary Medical Insurance: __________________________________ **Phone #:** ______________________
Name of Policy Holder: _________________________________ Relationship to Patient: ___________________
Policy Holder Date of Birth: ___________ Employer: __________________
PCP Referral Required? ☐ Yes ☐ No PCP:_________________________

Vision Plan: ____ **Phone #:** ______________________
Name of Policy Holder: _________________________________ Relationship to Patient: ___________________
Policy Holder Date of Birth: ___________ Employer: ____________________ID # _______________________

TECH RIDGE VISION
INFORMED CONSENT & TREATMENT AUTHORIZATION

The law requires that we make every effort to inform you of your rights related to your personal health information.

- I have read or had explained to me the *Notice of Privacy Practices* for Tech Ridge Vision and agree to continue my care with Tech Ridge Vision under said terms.
- I was given the opportunity but declined to read the *Notice of Privacy Practices,* for Tech Ridge Vision but wish to continue my care with Tech Ridge Vision under the terms of his privacy policies.
- I have read or had explained the *Notice of Privacy Practices* for Tech Ridge Vision and do not wish to continue my care with Tech Ridge Vision under said terms.
- The *Notice of Privacy Practices* could not be read due to the emergent nature of the care or the reason described as:

  ____

I hereby authorize Tech Ridge Vision to provide a diagnosis & optometric treatment to my child or me. I further authorize the release of Protected Health Information to additional physicians or optometrists in order to facilitate continuity of care. I have read & understand the above information & am signing this form voluntarily.

____ ______________________________

Patient or Legal Guardian's Signature Date

FINANCIAL & INSURANCE FILING POLICY

- ***All charges are your responsibility, whether or not your insurance company pays. Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We cannot become involved in disputes between you and your insurer regarding covered charges, deductible, or copay***
- *If your insurance company does not pay your claim within 30 days, it is your responsibility to contact them to expedite payment. If your insurance company refuses to pay, you are responsible for payment.*
- *If your insurance company does not pay within 45 days, we will require you to pay the balance by cash, check, money order, or Credit Card.*
- *Payment for copay and/or deductible is due at the time services are rendered.*
- *We accept cash, checks, money orders, Visa and Mastercard.*
- *Canceled or rescheduled appointments are subject to a fee if we do not receive 24 hours advance notice.*
- ***In the event that refraction is not covered by your insurance you will be charged a fee in addition to your copay and/or deductible***.

AUTHORIZATION TO RELEASE HEALTH INFORMATION & ASSIGN BENEFITS

I ________________________________, authorize the release of all necessary Protected Health Information & assign all medical & vision benefits to *Tech Ridge Vision.* I also request that payment of authorized Medicare (if applicable) benefits be made on my behalf to *Tech Ridge Vision* for any services furnished to me by *Tech Ridge Vision* . I authorize any holder of medical information related to me to release to the Centers for Medicare & Medicaid Services (CMS) & its agents, any information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests that payment be made & authorizes release of medical information necessary to pay the claim. If item 12 of the CMS 1500 claim form is completed, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the supplier agrees to accept the charge determination of the Medicare carrier as the full charge, & the patient is responsible only for the deductible, copay, & non-covered services. Copay & deductible are based upon the charge determination of the Medicare carrier. I understand that I am ultimately responsible for any bill incurred in this office. Should this account become delinquent, I will be responsible for any & all legal fees, court costs, & collection charges. There will be a service charge for each returned check. This authorization & assignment will remain in effect until revoked by me in writing. A photocopy of this authorization & assignment is to be considered as valid as the original. I request that you file my insurance & I have agreed to & completed all of the conditions listed above. I accept financial responsibility for all charges. I have read & understood this information & I am signing voluntarily.

____ ______________________________

Patient or Legal Guardian's Signature Date