

# HOOVER VISION CENTER

## 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 \_\_\_\_\_ Work Phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Email \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Retired \_\_\_\_\_ Disabled \_\_\_\_\_

If Student: Grade \_\_\_\_\_ School \_\_\_\_\_ Teacher \_\_\_\_\_

Who referred you to this office ? \_\_\_\_\_

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

Name	Relation	Age
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Person to notify in case of emergency \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to patient \_\_\_\_\_

### Insurance Information

Primary (*medical*) \_\_\_\_\_ Policy # \_\_\_\_\_

Secondary (*medical*) \_\_\_\_\_ Policy # \_\_\_\_\_

Vision Plan \_\_\_\_\_ Policy # \_\_\_\_\_

Name on card \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_

( Please have insurance cards available for receptionist to copy.)

### Financial Information

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

Guarantor: Last name \_\_\_\_\_ First name \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Relationship \_\_\_\_\_

**\*Please turn this form over and complete side two\***

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 copay, 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 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.**

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**Patient or Responsible Party Signature**

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**Date**