OLYMPIA EYE CLINIC
An NVISION® Eye Center

P: +1(360) 456-4800
F: +1(360)456-4812
www.NVISIONCenters.com

# Patient Information Form

**Last Name:** _____ **First Name:** _____ **M.I.:** _____

**DOB:** _____ **Age:**_____ **SSN:** _____ **Sex:** ☐ Male ☐ Female ☐ Undifferentiated ☐ Decline to Specify

**Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

***Phone Numbers:** Home ☐:_____ Work ☐:_____ Cell ☐:_____

** Check box next to phone number(s) where we may leave a message.* **Optional message language:* ☐ *Spanish* ☐ *Cambodian* ☐ *Vietnamese*

**E-mail Address:** _____

**Employer Name:** _____ **Occupation:** _____

**How were you referred to NVISION Eye Centers?**

☐ Doctor Referral: ☐ Family/Friend/Past Patient – Did they have refractive surgery with us? ☐ Yes ☐ No

_____ _____

** First & Last Name* ** Name & Relationship*

☐ Internet ☐ Drive-by ☐ Benefits Provider ☐ Other:

☐ Health/Workplace Event ☐ Newspaper/Magazine/Advertisement ☐ Radio _____

**Which of the following above influenced you the most to schedule an appointment with us?** _____

**Primary Physician** (Full Name)**:** _____ **Phone:** _____ **City:** _____

**Optometrist** (Full Name)**:** _____ **Office** (Name)**:** _____ **City:** _____

Has your optometrist discussed Laser Vision Correction with you? ☐ Yes ☐ No

Did they refer you to NVISION? ☐ Yes – Which surgeon were you referred to? _____

☐ No – Who were you referred to? _____

**Pharmacy:** _____ **Phone:** _____ **City:** _____

**Primary Insurance:** Insurance Co. Name:_____ ID#:_____ Group#: _____

Subscriber Name (if not self):_____Subscriber's Date of Birth (if not self): _____

**Secondary Insurance:** Insurance Co. Name:_____ ID#:_____Group#: _____

Subscriber Name (if not self): _____Subscriber's Date of Birth (if not self): _____

**Vision Insurance:** Insurance Co. Name:_____ID#:_____Group#: _____

Subscriber Name (if not self):_____Subscriber's Date of Birth (if not self): _____

**Emergency Contact Information/Designated Individuals Release:** NVISION Eye Centers may release to, or discuss my personal health information (PHI) (except regarding treatment ☐, payment ☐, and/or administrative operations ☐), with the individuals listed below, verbally or in writing. I understand that NVISION will make best efforts to verify the identity of the designated parties before disclosing PHI. I also understand that I may change any of the Emergency Contact Information/Designated Individuals Release information at any time in writing. **Appointment Reminder Release:** ☐ I authorize NVISION may release my name, treatment date, and contact information to a local partnering Optometrist who may prompt me with annual appointment reminder to facilitate follow up care.

Name: _____ Relationship: _____ Ph#: _____

Name: _____ Relationship: _____ Ph#: _____

My signature below indicates that the information provided above is accurate and complete to the best of my ability, and that you acknowledge you were advised of the Notice of Privacy Practices (NPP) for NVISION. Our NPP provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our NPP is subject to change. The notice of Privacy is available on our website at www.nvisioncenters.com and in our office. You may request a copy of the NNP.

_____ _____

*Signature of patient (if over 18) or patient's parent or legal guardian* *Date*

_____ _____

*If signed by parent or legal guardian, print name* *Relationship*

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# ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE OF PRIVACY PRACTICES AND PATIENT BILL OF RIGHTS

**Patient Name:** _____ **Date of Birth:** _____

**By signing below, you:**

- Acknowledge that you have been informed of the Privacy Practices and Patient Bill of Rights.
- Acknowledge that you have access to a copy of these documents in the center.

_____ _____
*Signature of patient* *Date*

**Are you completing this form for someone else?**

☐ Check here if you are signing as a personal representative, and complete below. Unless you're the parent of a minor child, please attach documented proof that you are acting on that person's behalf (for example, power of attorney)

_____ _____
*Printed name of patient's personal representative* *Date*

_____ _____
*Signature of patient's personal representative* *Relationship*

References Available on the Internet:
www.hospitalconnect.com/aha/about/pbillofrights.html
www.isrs.org
Other References:
Internal Society for Refractive Surgery Position Paper on Co-Management of Refractive Surgery Pre-operative and Post-operative Care, 2001 available form www.isrs.org

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## NOTICE TO CONSUMERS

**Medical Doctors are licensed and regulated by the:**

**Medical Board of California** www.mbc.ca.gov
**Oregon Medical Board** www.oregon.gov/OMB
**Washington Medical Commission** https://wmc.wa.gov/
**Nevada State Board of Medical Examiners** www.medboard.nv.gov
**Arizona Medical Board** www.azmd.gov

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# PAYMENT POLICY

**Name:** _____ **Date of Birth:** _____

## BASIC POLICY:

Payment for service is due in full at the time service is provided in our office.

## PATIENTS WITH INSURANCE:

## LASIK/REFRACTIVE SURGERY Is NOT A COVERED BENEFIT FOR MOST INSURANCE PLANS

Some treatments are billable to insurance, while others are not. NVISION doctors are contracted with Medicare and selective private insurances. If you have OUT-OF-NETWORK benefits and your NVISION provider is not contracted with your carrier, payment is due in full at the time of service. If we are not contracted with your insurance company, you have the ability to submit a claim to your insurance provider and NVISION will supply you with the necessary information to do so. NVISION does not guarantee that your insurance provider will reimburse for services rendered. NVISION is not responsible for denied insurance claims.

For NVISION Eye Institute patients, we will bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Co-payments and deductibles are due at the time of service. We can only bill for surgeon fees. You must contact the facility where your surgery is performed and inform them to bill facility fees, anesthesia, etc. on your behalf. We cannot guarantee that the facility is in network with your individual insurance company. You must contact the facility prior to your surgery to verify services will be covered. Since your agreement with your insurance is a private one, we do not routinely research why an insurance carrier has not paid or why it has paid less than participated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full by you.

## NON – COVERED SERVICES:

Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

## ASSIGNMENTS OF INSURANCE BENEFITS:

I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in lieu of the original. I understand I am financially responsible to NVISION for the charges incurred.

| | | | |
|---|---|---|---|
| **Have you met your deductible for the calendar year?** | ☐ Yes | ☐ No | ☐ Not Sure |
| Are you currently employed? | ☐ Yes | ☐ No | |
| Are your injuries accident related? | ☐ Yes | ☐ No | |
| Did you sustain an injury at work? | ☐ Yes | ☐ No | |
| Have you ever served in the military? | ☐ Yes | ☐ No | |
| Are you covered under an employer or union policy? | ☐ Yes | ☐ No | |
| Is your spouse or other family member employed? | ☐ Yes | ☐ No | |
| Do you have a secondary insurance policy? | ☐ Yes | ☐ No | |
| Are you covered under any other healthcare plan? | ☐ Yes | ☐ No | |

**I have read, understand and agree to the above financial policy for payment of professional fees.**
**I understand that I am ultimately responsible for all professional fees.**

_____ _____

*Signature of patient (if over 18) or patient's parent of legal guardian* Date

_____ _____

If signed by parent of legal guardian, print name Relationship