ADVANCED VISION & ACHIEVEMENT CENTER

(Please Print) Welcome To Our Office

Last Name _____ First Name_____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Work Phone _____ SS# _____

Employer/School _____ Email _____

How did you find out about our Office? _____ Medical Coverage _____

If under age 21: Parent or Legal Guardian's First & Last Name: _____

Parent/ Guardian's Employer _____ Parent/Guardian SS # _____

Primary Care Physician Name _____ Phone _____

Medical Information

Do you take medications for any of these systems? **(Please circle yes or no.)**

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary	Yes/No	Headaches	Yes/No
High blood pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please Explain _____

Diabetes Yes/No _____ Type _____ Date of diagnosis _____

Allergies to medication Yes/No Which? _____ Reactions?_____

Other health problems _____

Current medication(s) _____

Have you had any operations? Yes/No Kind? _____ When? _____

Name of family doctor and /or primary care physician _____

Date of last visit _____ Date your blood pressure was last checked _____

Family History

High blood pressure	Yes/No	Relation _____	Macular Degeneration	Yes/No	Relation_____
Diabetes	Yes/No	Relation_____	Retinal detachment	Yes/No	Relation_____
Glaucoma	Yes/No	Relation_____	Cataracts	Yes/No	Relation_____

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What Kind? _____

Have you had any eye operations? Yes/No Type _____ _____ Date _____

Have you had any eye injury? Yes/No Kind _____ Date_____

Do you have glaucoma?	Yes/No	Cataracts?	Yes/No	Dry eyes?	Yes/No
Macular degeneration?	Yes/No	Retinal detachment?	Yes/No	Blurred vision?	Yes/No
Do you wear glasses?	Yes/No	Contact lenses?	Yes/No	Type_____	

Additional information _____

Contact Person:

Our contact person(s) (other than yourself) for all questions, requests or for further information related to the privacy of your health information is:

_____

_____

Complaints:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to Kendall Dreyer, HIPPA Officer at the address, fax or E-mail shown above. If you prefer, you can discuss your complaint in person or by phone.

Changes to This Notice:

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised notice that will be posted prominently in our facility. Copies of this Notice are also available upon request in our reception area.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Neha Amin O.D., Mary Hardy, O.D., Notice of Privacy Practices.

Date: _____ Patient Name_____ Signature_____

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize the doctor to act as my agent in obtaining payment and I request that payment of the benefits be made either to me or on my behalf to Dr. Amin, O.D., Mary Hardy, O.D., for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agent as well as to any other insurance coverage needed to determine these benefits. My signature authorizes release of above medical information to the insurer or agency and authorizes my doctor to act as my agent.

Date_____ Patient Signature _____

Insurance

With most vision insurances we are given an authorization prior to services with a guarantee of payment. In the event that we are not given a pre-authorization the patient or account responsible is ultimately held accountable for the balance after services have been billed and correspondence from the insurance has been received. The information provided to us by the patient must be valid and current. This is not a guarantee of payment. Patient is responsible for deductibles, coinsurance, and non-covered services.

Date _____ Signature _____

OUR OFFICE POLICY REQUIRES PAYMENT UPON RECEIPT OF SERVICES

There is a $3.00 service charge on all billings. Any balance over 30 days is subject to a 1-1/2 % monthly finance charge. Accounts requiring collection assistance are subject an additional 40% in collection agency fees. Signature of person responsible for account indicates complete understanding of this policy.

Date _____ Signature _____