Vision Specialists of Annapolis

Today's Date:_____

Patient Information

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

Birth Date:_____ Social Security Number:_____

Sex: ○M ○F ☐Minor ○Married ○Widowed ○Single ○Divorced ○Partnered

Address:_____

City/State/Zip:_____

E-mail:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____

Guardian's Name (if applicable):_____ Relationship:_____

Primary Medical Insurance

Policy Holder:_____

Relationship to Patient:_____

Policy Holder DOB:_____

Insurance Company:_____

ID Number:_____

Secondary Medical Insurance

Policy Holder:_____

Relationship to Patient:_____

Policy Holder DOB:_____

Insurance Company:_____

ID Number:_____

Vision Insurance

☐Same as above

Policy Holder:_____ Relationship to Patient:_____

Policy Holder DOB:_____ Insurance Company:_____

ID Number:_____

Health History

Do you take any medications: ○Yes ○No If yes, please list below or attach a separate list:

_____

_____

_____

Do you have any of the following: Please check all that apply.

☐Dry Eye ☐Diabetes ☐Glaucoma ☐Arthritis ☐Cataracts ☐Sinus Trouble ☐Asthma

☐Thyroid Disease ☐Heart Disease ☐Cholesterol ☐High Blood Pressure ☐Allergies

Do you have headaches: ☐Never ☐Occasionally ☐Quite Often ☐Migraines ☐Sinus

☐When doing close work

Family History: ☐Cataracts ☐Glaucoma ☐Diabetes ☐Eye Disease ☐Lazy Eye ☐Heart Disease

☐High Blood Pressure ☐Macular Degeneration

Please list allergies to medications:

_____

_____

Financial Agreement:

Release of Information: I hereby authorize and direct Vision Specialists of Annapolis to release to government agencies, insurance carriers, or other who are financially liable for such professional and medical care, all information needed to substantiate claim and payment. Assignment of Insurance Benefits: I hereby authorize direct payment of my insurance benefits to Vision Specialists of Annapolis for services rendered to me by the physician or provider under his/her supervision. I understand that it is my responsibility to know my insurance benefits, and whether or not the services I am to receive are a covered benefit. I understand that I will be responsible for any balance due that Vision Specialists of Annapolis is unable to collect from my insurance carrier for whatever reason. I further agree and understand that this office can only code and file a claim for my visit with a diagnosis that was encountered and documented in my medical record.

Payment Requirement: Payment is expected at the time of your visit for any outstanding balances which could include: co-pay, coinsurance, unmet deductible or non-covered services. If you do not carry insurance, payment in full is expected at the time of your visit. Please note that outstanding balances may be subject to a $5.00 late fee every 30 days.

Insurance: Please be sure to check with your insurance company to verify we participate with your plan. It is your responsibility to provide us with your most current insurance information, along with a copy of your card and a photo ID. If you have a change in insurance coverage, please inform us immediately. As a courtesy Vision Specialists of Annapolis will file a claim to your insurance company. Please remember that insurance is a contract between you and your insurance company, and ultimately, you are responsible for payment in full. If your insurance company requires you to obtain a referral for your visit, it is your responsibility to obtain one. If your claim is rejected because you did not provide a referral, you will be responsible for payment in full.

Cancelled or Missed Appointments: If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a $35.00 missed appointment fee. These fees are not covered by insurance.

Collection Fee: In the event your account is placed in a collection status, fees incurred will be added to your outstanding account balance. This includes, but is not limited to, collection agency fees, court costs and interest.

By signing below, I verify that I have read and understand this financial agreement.

Signature:_____Date:_____