Welcome Back to Our Office

Please fill in the following information to help us provide you with optimum care

Today's Date_____ Date of Birth_____ Age_____ M / F SS#_____

Patient Name_____ Email Address_____

Address_____ City_____ State _____ Zip Code_____

Home Phone_____ Work Phone_____ Cell Phone_____

Emergency Contact: Name _____ Relationship_____ Phone_____

Occupation: _____

Current Medications (RX or over the counter) ☐ I provided a separate medication list

If not providing a separate list, list **all** medications including eye drops, vitamins & contraceptives below

_____

_____

_____

Allergies to medication (please list)_____

Are you a smoker? ☐No ☐Yes Drink Alcohol? ☐No ☐Yes

Name of Pharmacy of Choice: _____

Name of family physician/practitioner_____ Date of last visit: _____

Financial Policy / Insurance Information

We ask that all patients read and sign our financial policy prior to seeing the doctor.

1. Payments and all co-payments are due at the time of service. Please indicate your preferred method of payment today: ☐Check/Cash ☐Credit Card (Visa, Master, American Express or Discover ☐Care Credit
2. You will be responsible for all charges that are not covered by your insurance due to co-payments or deductibles.
3. There are no refunds for examinations, treatment, services or material purchases.
4. There will be a $30.00 fee for all returned checks and/or turning an account over to our collection agency and additional interest fees may also apply to accounts older than 60 days.

About Your Vision and Medical Insurance

There are two types of third party payors that will help pay for your eye care services and products. You may have both and our practice accepts both. The choice of which to bill is driven by your medical and eye history and/or your symptoms or issues brought up during the exam**. Please initial your understanding _____**

Assignment and Release: I hereby authorize third party or insurance payments to be made directly to Accent Vision Specialists and fully understand that I am the responsible party for all fees incurred by me at the above mentioned facility. I also authorize the release of any information required for the processing of those claims. I, the undersigned, have read and agree to the above policies.

Signature_____ Date_____

Patient (Parent or Guardian if minor)