PREMIER VISION GROUP

PATIENT INFORMATION

PATIENT NAME_______________________________DATE OF BIRTH___________
ADDRESS ____
CITY, STATE, ZIP CODE ____
TELEPHONE: HOME _______________ CELL________________WORK___________
E-MAIL ADDRESS:____
MALE FEMALE (PLEASE CIRCLE ONE) AGE____
SSN#____________________________
MARITAL STATUS (PLEASE CIRCLE ONE) MARRIED SINGLE WIDOWED OTHER
EMPLOYER_____________________________OCCUPATION ____________________

RESPONSIBLE PARTY

(IF PATIENT IS A MINOR)

NAME________________________________ RELATIONSHIP _______________
ADDRESS (IF DIFFERENT FROM ABOVE) _______________________________________
CITY, STATE, ZIP ____
PHONE ____________________________ EMPLOYER ____________________
SS# _______________________________OCCUPATION____________________

INSURANCE INFORMATION

SUBSCRIBER'S NAME __________________ Date of birth_____________________
SS#______________________________ EMPLOYER ____________________________
INSURANCE COMPANY______________________MEMBER ID_______________________

I authorize treatment of patient_____________________________Date of birth______________
I understand that it is my responsibility to know, whether or not the physician(s) with Premier Vision Group are participating providers on my plan and to know my coverage and eligibility status. I understand that my insurance contract is between my insurance company and me, and, that Premier Vision Group is billing my insurance company as a courtesy to me. I understand that I am responsible for the balance due on my account. I understand than any co-payment required is due when service is rendered, and, if my insurance cannot be verified during my appointment time, I must pay up front, in full, for any materials ordered. ___________(initial)

I understand that if I do not pay my account (or my dependent's account) in full, **within 90 days**, that my account may be assigned to a collection agency for collections. I understand that if my account is assigned to a collection agency, that the collection agency will charge a commission or fee that may be as much as **50 percent** of the amount I owe to Premier Vision Group. I understand, and agree, that if my account is assigned to a collection agency, that Premier Vision Group may add the amount of the collection agency's commission or fee to the amount that I owe Premier Vision Group, and, I agree to pay that additional amount. I understand and agree that in the event legal action is commenced to enforce my obligations hereunder, that I will pay court costs and reasonable attorney's fee. __________(initial)

*I authorize release of medical records to my insurance company, if required, for payment of claims.
*I authorize release of medical records to attending physicians for continuity of care.
I understand there will be a **$25.00 service charge for all returned checks. __________(initial)
**Photo I.D. is required for all checks and credit cards.

Signature of Patient or Guarantor_____________________________________
Relationship of patient__________________________Dated___________________