Patient Information **New Vision of Illinois, LLC**.

****PLEASE BRING INSURANCE CARDS TO FRONT DESK****

Patient's Last Name:	**First:**	**Middle:**	Marital Status: (Circle One) Single / Married / Div. / Widow

Birth date:	Sex : M F	**Race:**	**Language:**	**Ethnicity: (Circle One)** Hispanic or Latino Not Hispanic or Latino

Street address:			
City:	State:	ZIP Code:	**Social Security #**

Email address:	HOME PHONE	CELL PHONE	WORK PHONE

Primary Care Physician:	**Pharmacy:**

IN CASE OF EMERGENCY:

Name of local friend or relative:	Relationship to patient:		
	Home Phone #	Work Phone #	Cell Phone #

How did you find out about us? ❑ Insurance ❑ Radio ❑ TV Ad ❑ Internet/Website

❑Physician (Name):_____

❑ Friend/Relative (Name):_____

COMPLETE IF PATIENT IS COVERED UNDER PARENT'S OR LEGAL GUARDIAN'S INSURANCE

Parent or Legal Guardian Name:	**Social Security #**
Parent or Legal Guardian Birth date:	
Address (if different):	Phone #

Patient Name_____**D.O.B.**_____

CONSENT TO TREAT

I hereby authorize the consent to the administration and performance of such medical treatments and diagnostic procedures as may be deemed necessary during the course of my appointment by my physician or his/her assistants. I understand that not following medical advice and treatment recommended by my doctor may cause or contribute to poor outcomes including loss of vision and/or loss of life. I have been advised that my examination may include dilation of the pupils, which may impair my ability to drive.

FINANCIAL ASSIGNMENT AGREEMENTS

- I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to New Vision of Illinois LLC. for any services furnished me by them. I authorize any holder of Medical information about me to release to the Health Care Financing Administration, its agents, or any other insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing.

- I understand that I am financially responsible for all charges not covered by insurance. Unless I make prior arrangements, I will pay “out of pocket” charges at time of service. If I default and do not pay, New Vision of Illinois LLC. is entitled to the right of recovery of all collection expenses up to 50%, including all court costs and reasonable attorney’s fees incurred for the purpose of securing payment.

- I am aware that my HMO Insurance requires a referral and/or prior approval for treatment and I am aware that if a referral/authorization is not present at the time of treatment, I am financially responsible for charges related to that visit.

- Medical insurances (example: Medicare) do not pay for the examination required for glasses (refraction). I agree to be personally and fully responsible for payment.

- I authorize New Vision of Illinois LLC. to communicate with me by phone, answering machine, letter, email at home or business regarding appointments, care or billing.

CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION FOR THE TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I consent to the use and disclosure of protected health information by New Vision of Illinois LLC. and their workforce for treatment, payment and healthcare operations purposes.

Patient/Parent Signature: _____Date:_____
(**Patient**, Parent (if patient is a minor child)/ Legal Guardian, or authorized party)

Printed name of Power of Attorney (if applicable)

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******NOTE****A copy of P.O.A. document must be provided at time of service.**