**DATE:** ______________________ **PATIENT FULL LEGAL NAME:** ______________________________________________________________ ❑ M ❑ F

**SOCIAL SECURITY#** ___________________________ **DATE OF BIRTH:** ___________________

**ADDRESS:** ___________________________________________________________ **CITY:**______________________________ **STATE:** _____ **ZIP:**___________

**PHONE#:** ____________________________________ **CELL#:** ____________________________________ **WORK#:** __________________________________

**EMAIL ADDRESS:** _____________________________________________________ **MARITAL STATUS:** ❑ MARRIED ❑ SINGLE ❑ DIVORCED ❑ WIDOW

**ETHNICITY** (SELECT ONE): ❑ HISPANIC/LATINO ❑ NON HISPANIC/LATINO

**RACE:** (SELECT ONE) ❑ WHITE ❑ BLACK OR AFRICAN AMERICAN ❑ ALASKA NATIVE ❑ ASIAN

❑ AMERICAN INDIAN ❑ NATIVE HAWAIIAN ❑ PACIFIC ISLANDER ❑ DECLINE TO ANSWER OTHER __________

**PRIMARY CARE PHYSICIAN:** ___________________________________________________________ **PHONE#:** __________________________________

**ENDOCRINOLOGIST/DIABETIC DR.:** ______________________________________________________ **PHONE#:** __________________________________

**EMERGENCY CONTACT:** ______________________________________________________________ **PHONE#:** __________________________________

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It is the responsibility of each patient to determine which services are covered by their individual plan(s) prior to their appointment. Medical and vision plans vary in coverage. VSP will cover only a routine vision exam. Medical conditions such as diabetes, glaucoma, retinopathy, cataracts must be filed as a medical diagnosis to your major medical insurance. If you have an HMO, a referral from your primary care physician is required prior to your medical eye appointment. Refraction was deliberately excluded from the original Medicare Act of 1965, therefore the majority of medical plans do not cover refraction. Consequently, you will be responsible for the refraction fee at the time of service.

Your insurance company (medical or vision) will be billed based on your diagnosis, as determined by the physician the day of your exam. Our office is obligated to follow the mandates set forth by the insurance carriers. There is no way to determine the existence of one or more diagnosis prior to your exam, and co-pays may vary, depending on your individual coverages. Therefore collection of all co-pays, deductibles, non-covered services and coinsurance must be paid at the time of service. Insurance coverage and reimbursement will be determined by your plan. Any charges not paid at the time of service will incur a $25.00 statement fee. **INITIAL:** _________

**RELATIONSHIP TO PATIENT**:______________________________________________
(IF OTHER THAN SELF)

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It may be necessary for the office to leave a message for you regarding medical information such as test results, prescriptions, billing or account information or other health care issues.

**MAY WE LEAVE A MESSAGE ON YOUR:**
**HOME PHONE:** ❑ YES ❑ NO **WORK PHONE:** ❑ YES ❑ NO **CELL PHONE:** ❑ YES ❑ NO

Please list family members or friends who are authorized to speak with us about your health care issues. This includes spouses, children or parents.

**NAME:** ______________________________________________________ **RELATIONSHIP:** ____________________________ **PHONE NUMBER:** _______________

**NAME:** ______________________________________________________ **RELATIONSHIP:** ____________________________ **PHONE NUMBER:** _______________

This will remain in effect until it is revoked in writing.

**INITIAL:** __________________ **DATE:**______________________

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## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I was offered a copy of the Fox Valley Ophthalmology's Notice of Privacy Practices.

**PATIENT NAME:** _____________________________________________________________________________ **DATE:** ____________________________

**SIGNATURE:** _____________________________________________________________________

**IF NOT PATIENT STATE RELATIONSHIP:** ______________________________________________