Advanced Vision Family Eye Care
1633 Birchwood Ave. Ste. 105 Bellingham, WA 98225
T (360) 526-0075 F (360) 733-9150

PATIENT FINANCIAL INFORMATION SHEET

Name of Patient: ________________________________ DOB: _________________
Insurance Subscriber: ____________________________ DOB: _________________
Address (if different from patient) ____
City: ___________________ State: _______________ Zip Code: ____________

Minor Patient: ________________________________ Date: ___________________
Accompanying Adult/Gurdian/Parent

ROUTINE VISION INSURANCE INFORMATION

Insurance Company Name : ____________________________ **Subscriber ID#:** ____________________
Subscriber Name: ____________________________ **Relationship to patient:** ______________________
Subscriber DOB (if different from above) ___________________
Employer(if different from above) _______________________
Street (if different from above) ______________________ **City:** ____________ **State:** ______ **Zip:** ________
Work Phone # _____________________ **Cell Number:** ___________________________

MEDICAL INSURANCE INFORMATION

Insurance Company Name : ____________________________ **Subscriber ID#:** ____________________
Subscriber Name: ____________________________ **Relationship to patient:** ______________________
Subscriber DOB (if different from above) ___________________
Employer(if different from above) _______________________
Street (if different from above) ______________________ **City:** ____________ **State:** ______ **Zip:** ________
Work Phone # _____________________ **Cell Number:** ___________________________

Authorization and Release:

We will be happy to submit a claim to your insurance for you provided that you bring your insurance card with you to your visit and provide all the necessary information needed. If you choose to submit your claim we will provide you with the necessary documents. Your insurance policy is a contract between you and your insurance company. We are not a part to that contract.

_____ I authorize Advanced Vision Family Eye Care to verify and submit my insurance claim(s). I request payment to be made directly to their office.

_____ I acknowledge that billing my insurance is not a guarantee of payment and I am responsible for any balance. (Deductible amount, co-insurance, or any balance not paid by your insurance company) from the date the services are rendered unless other arrangements have been made.

_____ I authorize the release of any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

_____ If in the event my account is turned over to a collection agency. I will be responsible for collection costs, interest, attorney's fees and court costs.

Please note: The patient will also be responsible for submitting any reimbursements if proper information is not provided to office staff.

_____ Also, I understand that returns and/or exchanges of any prescription items, as seen necessary by a staff member, will be done so by office credit and no refunds will be given. Any eyewear/contact lens returns or exchanges may be subject to a restocking fee.

____ ___________________________
Patient/Guardian Signature (Sign over Printed Name) Date

HIPAA Privacy Practice acknowledgement

I have received or was offered and declined a notice of privacy practices.

Signature: ____________________________ **Date:** __________________________