WASHINGTON
VITAL VISION

ADULT REGISTRATION FORM

DATE: _____

Patient's Name: _____ Preferred Name: _____
Last *First* *MI*

DOB: _____/_____/_____ Birth Sex: ☐ Male ☐ Female Gender Identification:_____
MM DD YYYY

Marital Status: _____ Social Security Number (last four minimum): _____

Mailing Address: _____
Street *City* *St* *Zip*

Phone Numbers: _____
Preferred Phone (Check box) ☐ *Home* ☐ *Cell* ☐ *Work*

E-Mail address: _____ Referred by: _____

Would you like to receive electronic reminders of upcoming appointments? ☐ Yes ☐ No

How did you hear about Washington Vital Vision? (Check box below)

☐ Radio ☐ Newspaper ☐ Friends/Family ☐ Web Search ☐ Flyers ☐ Other: _____

ARE YOU IN A SKILLED NURSING FACILITY? ☐ Yes ☐ No If Yes, NAME:_____

Employer: _____Employer Phone: _____

Emergency Contact: _____ Relationship: _____
Last *First*

Phone Number: _____ Phone Type: ☐ Home ☐ Cell ☐ Work

Insurance Information:

Primary Insurance: _____ Effective Date: _____

Policy Holder's Name: _____ DOB: _____ Relationship: _____

Secondary Insurance: _____ Effective Date: _____

Policy Holder's Name: _____ DOB: _____ Relationship: _____

Vision Plan: _____ Effective Date: _____

Policy Holder's Name: _____ DOB: _____ Relationship: _____

ID # (if insurance card not issued):_____

OVER →

NOTE: COMPLETE BOTH SIDES OF THIS SHEET

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I realize that I am responsible for payment for all medical services rendered to me and/or my dependents, regardless of the decision to reimburse or not reimburse made by my insurance carrier. I also understand that my insurance will be billed as a courtesy to me. It is my responsibility to know my coverage terms, including the need for prior authorization. I hereby assign benefits to which I am entitled for medical and/or surgical expenses relative to the services performed. I am liable for all charges for services rendered. This authorization shall continue and be in full force and effect until revoked in writing by me. **If I refuse to sign below, I understand that my insurance will not be billed and I am prepared to pay, in full, all services rendered to me at the time of service.**

_____

Signature of patient or legal guardian. If not patient, please add relationship to patient *Date*

I am aware of the privacy standards of Washington Vital Vision and my rights and responsibilities as a patient under the Healthcare Portability Act of 1996 (HIPAA) and other governmental regulations. All exchanges of information including prescription history, medical history, and conversations about my condition will be in accordance with Washington Vital Vision's policy. I am also aware that there are times when Washington Vital Vision will share my medical chart with other physicians who participate in my medical care. By marking the appropriate box below, I give permission for Washington Vital Vision to share my medical records with others in the medical field to assist in my over-all medical care.

☐**I authorize** the practice to release any or all information concerning my medical care to other physicians, insurance carriers, and other medical institutions who collectively care in my healthcare.

☐**I authorize** the practice to release any or all information concerning my medical care to the individual listed as my **emergency contact.**

☐**I authorize** the practice to release any or all information concerning my medical care to the individual(s) **listed below:**

Name: _____ Relationship to Patient: _____Phone:_____

Name: _____ Relationship to Patient: _____Phone:_____

_____

Signature of patient or legal guardian. If not patient, please add relationship to patient *Date*

I understand that I may be charged for the following fees that my insurance may deem as non-covered benefits. I understand that fees are due at the time of services.

Refraction (test for glasses):	$65
Elective Contact Lens Fittings:	$130
DMV Report of Vision Exam:	$20
Disability Forms:	$50
Two consecutive missed appointments:	$50

The above information is true to the best of my knowledge.

_____

Signature of patient or legal guardian. If not patient, please add relationship to patient *Date*