Vision 162 (360) 944-1911 1901 NE 162nd Ave. Ste. D-102 Vancouver, WA. 98684
Shelby Wickhorst, OD

## Patient Information Form

Thank you for selecting our clinic! In order to help us meet your vision care needs, please fill out this form completely. If you need any assistance or have any questions, please feel free to ask us. All patients must complete our Patient Information form before being provided with services from Vision 162.

Name_____Today's Date_____
Address_____City,State_____Zip_____
Home Phone( )_____Work Phone(____)_____Cell Phone(____)_____
Social Security # of Patient_____
Date of Birth_____Age_____Male_____Female_____
Occupation_____Any Hobbies you have_____
Email_____
Date of Last eye exam_____Where?_____

Name of Primary Insured_____Date of Birth of Primary_____
Employer_____Insurance Plan_____
Social Security of Primary Insured_____
If you're a new pt., how did you find us? _____
**If there is family/spouse that can pick up your glasses or contacts please let us know who has your permission**_____

## Financial Policy

We are committed to providing you with the best possible care. If you have insurance, we will be happy to help you utilize the benefit provided through your insurance company.

**Regarding Insurance.** We will process your insurance claim, however any insurance claim not paid by **45** days from the date filed will become your responsibility. We will bill your insurance plan for you as long as you provide us with **correct and current information.** We must emphasize that as health care providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are ultimately **your** responsibility. Please be aware that some, and perhaps all, of the services Vision 162 provides may be a non-covered service or product under your insurance plan. **You** are responsible for payment regardless of any insurance company's determination of usual and customary rates. If temporary financial problems are affecting timely payment of your account, we encourage you to contact us promptly to work out a payment option that will work for both of us. **Payment plans must have prior approval of the Office Manager. If approval is made there is a $4.oo late fee applied for every 30 days there is a balance over $10.00 and a $25.00 charge for any returned checks. If there is no activity recorded for 60 days the account will be transferred to collections with a $25.00 late fee.**

**All co-pays are due at the time of service. Any merchandise will have a return policy of 24 hours after the order date. If merchandise is returned after the 24 hour period then there will be a charge of ½ the original cost.**

**Medically necessary care:** Vision 162 will only provide you with a service if we consider it medically necessary. Therefore, if your insurance company arbitrarily determines that a service we have rendered to you is unnecessary, you will be responsible for the bill.

## Vision 162's Privacy Policy

Vision 162 follows the HIPPA Privacy Policies that went into effect April 14th, 2003. We protect your personal health information against disclosure to unauthorized entities/person. With your permission we will share your personal health information only with entities/persons directly related to your health care and insurance payment needs. You have the right to review and amend your personal health care records. Fees for copying your personal health information/records are set by state regulators.

I understand the HIPPA Policies that Vision 162 follows and I agree to them. I understand that for Vision 162 to receive insurance payments they will need to disclose information about my personal health to my insurance company and I hereby give them permission to do so. By signing below I acknowledge the privacy policy and the understanding of the financial policy for Vision 162. I am authorizing Vision 162 to perform exams and services.

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Signature of the Patient, or the Guardian of a Minor Date