Absolute Vision Care
"Your pediatric and family eyecare specialists"

Welcome to Absolute Vision Care

Patient's Name	_____	**Policyholder's Name**	_____
Patient's E-Mail	_____	**Relationship to Patient**	_____
Patient's Home No.	_____	**Policyholder's Birth Date**	_____
Patient's Work No.	_____	**Policyholder's SSN**	_____
Patient's Cell No.	_____	**Policyholder's Employer**	_____
Person Responsible for Payment	_____	**Policyholder's Work Phone**	_____
Guarantor's Name	_____	**Guarantor's Phone**	_____
Guarantor's Address	_____		

Absolute Vision Care Practice Policies

In order to serve your needs better, we ask that you read our policies and sign below

1. We request a 24 hour cancellation notice.
2. We request that you do your best to make it on time for your appointment.
3. All minors under the age of 16 must be accompanied by an adult or guardian.
4. We attempt to make courtesy phones calls and emails to remind you of your appointment.
5. We request that all patients bring their current medical and/or vision insurance cards at the time of your appointment.
6. Patients are responsible for verifying insurance coverage and making sure we are a network provider.
7. If we are not a preferred provider of your insurance company, payment is due at the time of service and we will give you a detailed fee sheet to send to your insurance company. All co-pays are due at the time of service. We have a list of participating insurances available in each office.
8. Patients must bring their current glasses and/or contacts to their vision examination. New patients must bring any contact lens packaging.
9. All patients must bring/know a list of medication currently prescribed as this could impact your vision examination and/or treatment.
10. All returned checks will be charged a $25.00 administrative fee and your account will be placed on a cash only basis.
11. If a personal balance goes past 90 days with no correspondence by you, we will assume you do not intend to pay your bill. Patients will be liable for collection costs and reasonable attorney fees. Future appointments will not be scheduled until the balance is paid in full or a payment plan has been set up.

Please understand we participate with many vision and medical plans (including Medicare), but their rules change often, and each company has numerous plans, so please keep up to date with changes in your plans, so that we can better serve you and your family. ***I have read and understand the above practice policies.***

_____	_____	_____	_____
Signature	**Relationship to Patient**	**Patient Name (please print)**	**Date**

Assignment and Release

I, the undersigned, certify that I (for my dependent) have insurance coverage with the insurance companies on record. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. ***I authorize the use of this signature on all insurance submissions.***

_____	_____	_____
Responsible Party Signature	**Relationship**	**Date**

Acknowledgement of Receipt

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the Notice of Privacy Practices from Absolute Vision Care.

_____	_____	_____
Responsible Party Signature	**Relationship**	**Date**