

# Advanced Laser Vision & Surgical Institute

## PATIENT INFORMATION SHEET

NAME:	_____	NICKNAME:	_____			
ADDRESS:	_____	APT:	_____			
CITY:	_____	STATE:	_____	ZIP:	_____	
HOME PHONE:	_____	WORK:	_____	x	_____	
CELL PHONE:	_____	EMAIL:	_____			
DATE OF BIRTH:	_____	SEX:	M	F	SS#:	_____
MARITAL STATUS:	_____	TDL#:	_____	TYPE OF WORK:	_____	
PRIMARY CARE PHYSICIAN:	_____	PHONE:	_____			
NAME OF YOUR REGULAR EYE DOCTOR:	_____	DATE OF LAST EXAM:	_____			
Do you have vision care insurance? YES or NO If yes, Name of Insurance _____						
EMERGENCY INFORMATION: CONTACT _____ Phone _____						

## INSURANCE INFORMATION/RESPONSIBLE PARTY INFORMATION

Name:	_____	DOB:	_____	SS#:	_____		
Relationship to patient:	_____	Employer:	_____				
Responsible party address:	_____	City:	_____	State:	_____	Zip:	_____
Insurance Company:	_____						

It is our policy to accept and file insurance for our patients, when applicable. If you are covered under an HMO or PPO policy, it is your responsibility to notify the receptionist that you are covered by a certain plan and you must have your insurance card and referral (if necessary) **BEFORE SERVICES ARE RENDERED**. All deductibles and co-payments will be collected at the time of service. We will bill your insurance for the balance due.

**IF YOUR INSURANCE REQUIRES A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN AND IT HAS NOT BEEN RECEIVED BY OUR OFFICE PRIOR TO EACH VISIT YOU WILL BE REQUIRED TO PAY FOR THAT VISIT OR RESCHEDULE YOUR APPOINTMENT.**

I hereby authorize Advanced Laser Vision & Surgical Institute to release any and all medical information to my insurance company to process any and all claims for reimbursement on my behalf. I hereby authorize payment of all medical, surgical and vision insurance benefits to be issued to Advanced Laser Vision & Surgical Institute. I also agree to pay any and all co-payments and deductibles as required by my insurance company.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

How were you referred to our office?	Doctor _____	Magazine/Newsprint _____	Internet _____	Radio/TV _____
Family Member _____	Personal Friend _____	Name: _____	(We love to give credit to our referring patients)	
Other: _____				

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## PATIENT ACKNOWLEDGMENT FORM

Our "Notice of Privacy Practices" provides information about how we may use and disclose protected health information (PHI) about you. It applies to the information and records we have about your health, health status, and the health care and services you receive at this office. The date of the most recent Notice will appear in the upper right hand corner. By signing this form, you are simply acknowledging that you have been offered or have received a copy of our "Notice of Privacy Practices."

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Office Representative Signature

### TO OUR MEDICARE PATIENTS - Advanced Beneficiary Notice

Medicare does not pay for all of your health costs and only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does NOT mean that you should not receive it. Your doctor may recommend this item or service even though it is not a covered item.

MEDICARE WILL NOT PAY FOR REFRACTIONS – The measurements necessary to prescribe glasses or contacts lenses. The fee for this service is **\$35.00** payable at the time of service.

MEDICARE WILL NOT PAY FOR PREMIUM INTRAOCULAR LENSES INCLUDING: Restor, Rezoom, Crystalens, Toric or other new technology intraocular lenses. These lenses are considered DELUXE items. This fee will be discussed with you at the time cataract surgery is discussed.

MEDICARE WILL NOT PAY FOR REFRACTIVE SURGERY INCLUDING LASIK & PRK.

\_\_\_\_\_  
Patient Signature (Parent for minor)

\_\_\_\_\_  
Date

### **DO NOT WRITE IN THIS BOX - FOR OFFICE USE ONLY**

Examining Doctor: \_\_\_\_\_ Surgeon W. Lipsky M.D.      OD   OS   OU

Date of Planned Procedure: \_\_\_\_\_ All testing Complete Y/N Comment \_\_\_\_\_

Procedure: Lasik \_\_\_ PRK \_\_\_ PTK \_\_\_ PRELEX \_\_\_ PHACO \_\_\_ Multifocal IOL Y/N \_\_\_\_\_

Price \$ \_\_\_\_\_ P/EYE    DISCOUNT TYPE \_\_\_\_\_ \$ \_\_\_\_\_

Deposit \$ \_\_\_\_\_ Other \_\_\_\_\_ BALANCE \$ \_\_\_\_\_

Financing Notes \_\_\_\_\_

RX Zymar \_\_\_ Vigamox \_\_\_ Loracet 10-650 \_\_\_ Darvocet N-100 \_\_\_ Ambien 10mg \_\_\_  
Maxitrol \_\_\_ Acular \_\_\_ Nevanac \_\_\_ Restasis \_\_\_ Acyclovir 400mg \_\_\_

Preop orders and consents given to patient: Y or N    BY \_\_\_\_\_

**I have received a copy of the VISX FDA Booklet:    Initials \_\_\_\_\_    Date \_\_\_\_\_**