

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: _____
Other: _____
(We love to give credit to our referring patients)

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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 _____