MICHELSON LASER VISION

Patient Name:_____ Today's Date: _____
Last First Middle

Home Address_____

City_____State_____ Zip Code_____

Home Phone_____ Cell Phone_____ E-mail address_____

Preferred method of contact: Phone_____Text_____E- mail_____ Marital Status Single Married Divorced Widowed

Social Security Number_____ Date of Birth_____ Age _____ Gender M F

Employer/Parent's Employer_____Occupation_____

Work Address_____Work Phone: _____

City_____State_____Zip Code_____

Spouse name (Parent name if minor) _____Spouse/Parent Work Phone_____

Person to notify in case of emergency (other than spouse) _____

Phone number (s) _____Relationship_____

Primary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

Secondary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

_____ _____

Patient's signature **Today's date**

MICHELSON LASER VISION

PHARMACY INFORMATION:

_____	_____	_____	____	(___) _____
Preferred Pharmacy	Street Address	City	State	Phone #

PHYSICIAN INFORMATION:

_____	_____	_____	____	(___) _____
Referring Physician	Street Address	City	State	Phone #
_____	_____	_____	____	(___) _____
Primary Care Physician	Street Address	City	State	Phone #
_____	_____	_____	____	(___) _____
Other Physician (Name & Specialty)	Street Address	City	State	Phone #

Responsible Party Information: (If not patient)

Name: _____

Mailing Address: _____

Phone #: _____ Relationship to Patient: _____

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I authorize my physician and/or administrative and clinical staff of **Michelson Laser Vision** to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name and relationship of person(s) who you wish to allow access: (e.g., your spouse, son, daughter, sibling, caretaker, and friend)

Name of Person or Entity: **Relationship:**

I have been provided a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read and understand and consent to use and disclosure of protected health information about myself for treatment, payment, and health care operations.

_____ Signature of the Patient or Patient Representative

I have been provided a copy of the Financial Policy to read. I understand that I, the patient, or the patient's representative, am/is responsible for payment of all charges for service rendered. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice.

_____ Signature of the Patient or Patient Representative

MICHELSON LASER VISION

PROFESSIONAL FEE ACKNOWLEDGEMENT & RECEIPT

Initial consultation of new patients – no charge

Evaluation & Examination for Laser Vision Correction - $150.00

I (the patient) am completely aware of the fee in the amount of **$150.00** for the evaluation and examination for laser vision correction provided by the physicians and staff at Michelson Laser Vision.

This fee must be paid in full and will be collected at checkout. This fee will be applied **to the total amount due for laser refractive surgery** at Michelson Laser Vision. and provides for the privilege of having your records released.

This fee is not refundable if the physicians determine you are not a candidate for laser vision correction or you decide not to have laser vision correction.

This fee is not for the initial consultation of new patients, but for the examination performed by the physicians and staff of Michelson Laser Vision to determine if you are a candidate for laser vision correction.

Patient's Name (printed) Date

Patient's Signature (or legal responsible party) Relationship to patient