

Silk Vision and Surgical Center

3301 Woodburn Rd. Suite 308
Annandale, VA 22003
Tel. 703.876.9700 Fax 703.876.9701

Patient Information

Date: _____ Account #: _____

Patient Name: _____ Age: _____

Last

First

MI

Patient DOB: ___/___/___ Patient SSN: _____ - _____ - _____ Marital Status: _____

Sex (M/F): _____ Employed (Y/N): _____ Student (Y/N): _____

Employer/ School Name: _____

Home Address: _____

City _____ State _____ Zip Code _____ Email: _____

I'd like to receive special offers and Silk Vision's Eye Care newsletter via email, sign me up!

Check here to opt out

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Work Phone: (____) _____ - _____ Other Phone: (____) _____ - _____

Responsible Party: _____

Type of Injury: Auto: _____ W/C: _____ Other: _____ Date of Incident: _____

Billing Address (If not the same as above): _____

Referred By: _____ Primary Care Dr: _____

Person to Notify in Case of Emergency: _____

Relationship to Patient: _____ Emergency Phone: (____) _____ - _____

Race: (Please circle one): Caucasian, Asian, African America, Hispanic/Latino other: _____

Ethnicity: (Please Circle one) Hispanic/Latino or Not Hispanic/Latino

Preferred language: _____

Preferred pharmacy phone and or address: _____

PLEASE COMPLETE INSURANCE INFORMATION

I understand that it is my responsibility to know what my insurance does or does not cover and whether or not my insurance is in-network or out of network and I understand that I am financially responsible for paying all non-covered services.

Primary Insurance: _____ Phone: (____) _____ - _____

ID/ Policy #: _____ Group #: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Policyholder: _____ Sex: _____ DOB: ___/___/___

Policyholder's Address: _____ Phone: (____) _____ - _____

Policyholder's Employer/ School Name: _____

Is Insurance through Employer? (Y/N): _____ Relationship to Patient: _____

Secondary Insurance Carrier: _____ Phone :(____) ____ - _____

ID/ Policy #: _____ Group #: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Policyholder: _____ Sex: _____ DOB: ____/____/____

Policyholder's Address: _____ Phone: (____) ____ - _____

Policyholder's Employer/ School: _____

Is Insurance through Employer? (Y/N): _____ Relationship to Patient: _____

Please Read: I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I understand if I have insurance and have provided accurate and complete information regarding my insurance, my charges will be filed with my insurance carrier; however, the financial responsibility for services rendered to a patient ultimately rests with the patient or responsible party. I understand that my co-pay and/or any coinsurance money are due at the time of service. If I do not have insurance or my charges are not to be filed with insurance, payment in full is due at the time of service. I agree to reimburse Silk Vision the fees of any collection agency, which will be added to the account at the time it is placed with an agency for collection and may be based on a percentage at a maximum of 31% of the debt, and all reasonable costs and expenses, including reasonable attorneys' fees, incurred in such collection efforts. I hereby authorize assignment and payment directly to Silk Vision and Surgical Center, major medical benefits due me for services provided by them.

Patient Signature

Signature of Authorized Person

Date

HIPAA Statement:

I have read Silk Vision and Surgical Center's Notice of Privacy Practice. I hereby authorize, Silk Vision and Surgical Center to furnish to my insurance company or authorizing agency, information regarding my protected health information, for the purposes of treatment, payments or healthcare operations. I further authorize the physician(s) of Silk Vision and Surgical Center to consult as needed in their sole discretion with other medical providers regarding my medical care. I wish to place the following restrictions concerning the disclosure of my protected health information:

Silk Vision and Surgical Center, may discuss my medical information/ condition with the following People:

1:

2:

3:

Patient Signature

Signature of Authorized Person

Date