MICHELSON LASER VISION, INC.

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**

PHARMACY INFORMATION:

Preferred Pharmacy	Street Address	City	State	Phone #
___________________________	_____________________________	____________	____	(___) _____________

PHYSICIAN INFORMATION:

Physician	Street Address	City	State	Phone #
Referring Physician ___________________________	_____________________________	____________	____	(___) _____________
Primary Care Physician ___________________________	_____________________________	____________	____	(___) _____________
Other Physician (Name & Specialty) ___________________________	_____________________________	____________	____	(___) _____________

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, Inc.** 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, INC.

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, Inc.

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, Inc. 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, Inc. to determine if you are a candidate for laser vision correction.

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Patient's Name (printed) Date

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