iCare Vision Centers

110 Coshocton Ave.
Mt. Vernon, OH 43050
Phone: (740) 392-4000 Fax: (740) 392-6379
www.icarevision.com

Date: | Year 1 – Black/ Year 2 – Red/ Year 3 – Green

PATIENT INFORMATION

LAST NAME	FIRST NAME	M.I.	What do you prefer to be called?

SEX (M F)	AGE	DATE OF BIRTH	SOCIAL SECURITY NO.	MARITAL STATUS (CIRCLE ONE)
M F				NEVER MARRIED ANNULLED DIVORCED DOMESTIC PARTNER INTERLOCUTORY MARRIED POLYGAMOUS WIDOWED LEGALLY SEPARATED

ADDRESS (STREET # & NAME)	CITY	STATE	ZIP	HOME PHONE
				( )

EMAIL ADDRESS	MOBILE PHONE	SPOUSE'S NAME	IF UNDER 18, GUARDIAN'S NAME
	( )		

EMPLOYER	OCCUPATION	WORK PHONE
		( )

RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE) LAST NAME	FIRST NAME	M.I.	HOW DID YOU HEAR ABOUT US?

RESPONSIBLE PARTY'S ADDRESS	STREET #	STREET NAME	CITY	STATE	ZIP

Please list below all individuals with whom we may talk with about your medical concerns and/or share medical information with:

PLEASE NOTE: We will not release any personal health information to anyone else unless they are listed below

Name: **Relationship:**

Name: **Relationship:**

Name: **Relationship:**

INSURANCE INFORMATION

VISION INSURANCE

INSURANCE CO. NAME		
SUBSCRIBER	DATE OF BIRTH	SSN
EMPLOYER	RELATIONSHIP TO PATIENT	

MEDICAL INSURANCE

INSURANCE CO. NAME		
SUBSCRIBER	DATE OF BIRTH	SSN
EMPLOYER	RELATIONSHIP TO PATIENT	

OVER

AUTHORIZATIONS

1.) Consent for Treatment: I hereby consent to and authorize all treatments by iCare Vision Centers.

2.) If I am self-pay or carry insurance that iCare Vision Center is not contracted with, I understand that payment is expected at the time of service and it is my responsibility to file the claim with my insurance carrier.

3.) If iCare Vision Center is contracted with my insurance company, I request that payments of authorized benefits be made directly to them. I authorize release to my insurance carrier(s) any medical information about me needed to determine these benefits. Regardless of my insurance benefits, I understand I am financially responsible for all charges. Any applicable co-pays are due at the time of service.

4.) If I am unable to keep a scheduled appointment, I understand that I need to notify the office at least 24 hours in advance or I may be charged a minimum office charge of $25. I understand this charge is not covered by insurance plans.

5.) I have received a copy of iCare Vision Center's Notice of Privacy Practices.

PRINT NAME: _____ **DATE:** _____

SIGNATURE: _____

Parental or guardian signature required if patient is under 18 years of age

SIGNATURE SECOND YEAR: _____ **DATE:** _____

SIGNATURE THIRD YEAR: _____ **DATE:** _____