- ***Welcome:*** to **A**DVANCED **V**ISION **C**ENTER, the office of **Dr. Ingryd Lorenzana** and Staff.
- We **THANK YOU** for the privilege of trusting us with the care of your vision needs.
- We hope you will find that you are **VALUED** here and we encourage you to ask questions.
- By completing this registration you will assist us in providing you thorough and high quality vision care.

PATIENT INFORMATION:		
Name:	Birth date: / /	SS#:
Address:		
City:	State:	Zip code:
Cell phone:	Work phone:	
Home Phone:	Gender: M ____F____	
Email address:	Occupation:	
Race:	Primary Language:	
Ethnicity:		

ACCOUNT RESPONSIBLE, IF MINOR	**SAME AS ABOVE:**	
Name:	Birth date: / /	SS#:
Address:		
City:	State:	Zip code:
Cell phone:	Work phone:	
Home Phone:	Gender: M ____F____	
Email address:		

MEDICAL INSURANCE:	Company name:	
Member's name:		Birth date: / /
Member's ID Number and Group:		
Member's employer name and address:		
Member's SS#:		
City:	State:	Zip code:

VISION PLAN:	Company name:	
Member's name:		Birth date: / /
Member's ID Number and Group:		
Member's employer name and address:		
City:	State:	Zip code:

ASSIGNMENT OF BENEFITS: (BY SIGNING THIS YOU GIVE PERMISSION TO BILL YOUR INSURANCE)

I certify that the information given by me in applying for INSURANCE and/or MEDICARE, KIDCARE payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my for INSURANCE and/or MEDICARE, KIDCARE benefits and I request that payment of these benefits be made either to me or on my behalf to **ADVANCED VISION CENTER** for any services and materials furnished. I authorize any holder of medical information about me be released to the centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to the related services. If I have other insurance coverage (as indicated in item 9 of the cms- claim form or electronically submitted), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes to act as my agent as above.

Lifetime Patient Signature:	**Date:**

PLEASE READ CAREFULLY:

IMPORTANT BILLING, INSURANCE AND FINANCIAL POLICY

- **Patients ARE RESPONSIBLE** for the **cost** of **SERVICES/MATERIALS** rendered **REGARDLESS** of **INSURANCE.** AS a COURTESY to our patients, ADVANCED VISION CENTER will file a claim on your behalf to your health insurances. Please REMEMBER INSURANCE COVERAGE **is ONLY FINAL** until the claim is **SUBMITTED and the insurance reimbursement is received.** IF you overpaid in estimated co pays you will be reimbursed the difference**. HOWEVER, if PAYMENT** from insurance is **LESS** than originally estimated **YOU WILL BE RESPONSIBLE FOR THE DIFFERENCE** and you will receive a statement.

- All co pays and non- covered services are due at the time service is rendered

- A monthly statement will be sent to the patient or guarantor until the account is paid in full.

- Patient unable to pay the account balance **in full within 15 days** of receipt of this statement should contact our office promptly to make acceptable payment arrangements with our office. Please call us at **847-891-8003**

- Any **ACCOUNT OVER 45 DAYS OLD** that are **not brought current**, REGARDLESS of insurance situation, **will be forwarded to a collection agency. In addition to the principle owed, I agree to pay 33.33% of the unpaid balance as a collection fee if my account is turned over to a collection agency. I further agree to pay reasonable attorney fees and court cost arising out of any litigation concerning the collection of this account.**

- **Any follow up required for payment from your insurance carrier is strictly the patient's responsibility.**

- It is important to remember that insurance coverage varies and that not all services may be covered. We cannot be responsible for negotiating payment from your insurance company even though they may use such terms as customary, reasonable, prevailing, etc., to limit coverage. **Payment of our charges for service/materials rendered remains the patient's obligation.**

Secondary Insurance Claims

- It is possible for us to file a claim with your secondary insurance carrier. Please send us a copy of your primary insurance carrier's statements (Explanation of Benefits) along with your secondary insurance information and we will file a claim.

Third Party Litigation

- We do not get involved in any third party liability cases. It is the patient's responsibility and obligation to see that the bill is satisfied promptly, regardless of any pending litigation resulting form an injury cased by a third party. We will file liability liens against the patient and/or responsible party whenever deemed necessary to protect our interests.

By signing this agreement I acknowledge that I have been made aware of and I'm willing to comply with Advanced Vision center's billing and financial policy.

Patient / Parent or legal guardian: _____DATE: _____

ACKNOWLEDGEMENT OF RECEIPTS OF HIPAA NOTICE PRIVACY PRACTICES:	
I have received a copy of the privacy practices of AVC which are also available on AVConline.org Additionally, I affirm that all information I've supplied to AVC is complete and accurate to the best of my knowledge.	
Signature:	**Date**: