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: ____

Address: _________________________________ Email: _________________________________

City: ____________________ State: ______ Zip: __________

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: (_____)______-________

Medical Allergies:____

Insurance Information

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. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me, I agree to pay all reasonable attorney's fees (33.33%) and any other court costs or costs of collection. 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**

HIPPA 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:

______________________________	______________________________	_____________
Patient Signature	**Signature of Authorized Person**	**Date**