# 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: _____**

## 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. 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 (40%) 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**

**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**