# Vision Source - South Valley
# Patient Information

Thank you for choosing our practice for your eyecare needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help. (Please Print)

Name_____________________________________________________ Today's Date___________________
First MI Last
Address ____________________________________ City__________________ State_____ Zip__________
Phone: Home ______________________________ Birthdate_________________Age______Sex_____
Work ______________________________ Social Security #____________________________
Cell ______________________________ E-mail address______________________________
Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Cell ☐ Other
Are you: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Your Employer______________________________________ Occupation _____________________________
Business Address_______________________________ City ___________________ State ____ Zip_________
Spouse's or parent's name _______________________________ Employer ___________________________
Work phone _________________________
If you are a student, name of school/college ________________________________ City__________ State_____
How did you hear about us? ☐ Patient referral _________________ ☐ Insurance list ☐ Yellow pages ☐ Other
Person to contact in case of emergency_______________________________ Phone #_____________________
How are you paying for today's services? ☐ Cash ☐ Check ☐ Credit Card ☐ Insurance

## Responsible Party

Name of person responsible for this account?__________________________________________________
Relationship to patient______________________________________ Phone #___________________________
Address________________________________________City_________________State_____Zip__________
Name of employer______________________________________ Work phone #_________________________

## Insurance Information (Please list vision insurance first - medical insurance second)

Name of insured _____________________________ Relationship to patient ________________________
Insured's Date of Birth _________________________
Insurance Company____________________________ ID number___________________________________
Ins. Address_________________________________ Group name/number__________________________
City___________________State_____Zip_________ Ins. Phone #__________________________________
Other Insurance: (secondary insureance or medical insurance that would cover injury/disease of the eyes)
Name of insured______________________________ Relationship to patient _______________________
Insured's Date of Birth _________________________
Insurance Company ____________________________ ID number___________________________________
Ins. Address _________________________________ Group name/number__________________________
City__________________ State_____Zip__________ Ins. Phone #_________________________________

My signature below indicates that I have read the following and:

1) I understand that professional fees are non-refundable fees for services rendered and are due today;
2) All materials (glasses, contact lenses, etc.) must be paid for in full before they are ordered and are not returnable or refundable;
3) For insurance:
   - I request that all benefits under the above-named policy(ies) be paid directly to Dale F. Hardy, OD PC
   - I authorize release of any information necessary to allow payment of this claim.
   - I agree to pay all co-payments, deductibles, or non-covered extras when services are rendered and/or before materials are ordered [see 1) and 2) above.]
   - I understand that insurance is a contract between my insurance company and me and agree to pay any balance not paid by my insurance company within 45 days of the billing date.
4) I agree that a FINANCE CHARGE equal to 1½% per month (ANNUAL 18%) on the unpaid balance, or a minimum charge of $5.00, whichever is greater, may be added to my account after 30 days and each month until my account has been paid in full.
5) Should it become necessary to send my account to collections, I agree to pay an additional 40% collection fee, and all legal fees, with or without suit, including all attorney fees and court costs.

Signature of Responsible Party ____________________________________________ Date ________________

Relationship to Patient __________________________________________

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