Visions Medical Center
A Complete Approach to Health

Patient Registration & HIPAA Acknowledgment

Patient Name: ______________________________ Birthdate: ______________

Age: ______ Sex: ________ Marital Status: ______________ SS#: ________________

Patient Street Address: ____

Patient City, State, Zip: ____

Home Phone: _________________________ Work Phone: _______________________

Cell Phone: ______________________ Email: _______________________________

Insurance Company: __________________________ ___ Policy #: __________________

Insurance Subscriber: ___________________________ Subscriber DOB: ______________

Emergency contact, relationship, phone #: ____________________________________

Name of primary care doctor: ________________________ Phone #: _________________

I, ____________________________________, acknowledge that I have received a copy of Visions Medical Center's Notice of Privacy Practices (HIPAA).
Please sign below to indicate that you have read and understand the privacy policy.

Patient Name (please print) Patient's or Legal Guardian's Signature Date

I request that payment of authorized Medicare/Other Insurance company benefits be made on my behalf directly to Visions Medical Center for any services furnished me. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare/Other Insurance company or a related Medigap claim. I permit a copy of this authorization to be used in place of the original.

Signature & Date

If your insurance is an HMO or managed care plan, you must obtain a referral from your primary care physician. As a member of a managed care plan, I understand I have an obligation to have all medical care coordinated by my PCP. I understand that I will be personally responsible for payment for services received if denied by my insurance carrier or if I do not have a referral from my PCP for any service dates.

Signature & Date

Please be advised that should you miss a scheduled appointment with any Visions practitioner without providing at least 24 hours prior notice, you will be charged a cancellation fee at that practitioner's discretion.