Today's date _____ / _____ / _____

1 Patient Information

Patient name: _____ Date of birth: _____/_____/_____

Address: _____ City, State, Zip: _____

Preferred phone number: ( )_____ Other phone number ( )_____

Occupation _____ Employment status: □ full-time □ part-time □ other_____

Employer: _____Email address _____

Marital status: □ Married □ Single □ Other: _____

Parent/Guardian Name (if applicable) _____ How did you hear about us? _____

What is the main reason for your visit today? _____

2 Insurance Information

VISION INSURANCE CO. _____ Policy / ID # _____

Guarantor/Insured's name _____ Date of birth _____/_____/_____ Last 4 digits of SS# _____

Patient's relation to guarantor: ☐Self ■Spouse ☐Child ☐Other _____

MEDICAL INSURANCE CO. _____ Policy / ID # _____

Guarantor/Insured's name ☐ Same as above or _____

Assignment and Release: I, undersigned, certify that I (or my dependant) have (has) insurance coverage with the aforementioned companies and assign directly to Dr. Jessica P. Graham all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that whether it is this office or myself that verifies my insurance benefits, it is my responsibility to know what my coverage is. I hereby authorize the doctor to release information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____	_____	_____	_____
Responsible Party Signature	Print name of Responsible Party	Relationship to Patient	Date

3 Lifestyle Questionnaire

	This is me	"Sort of" me	This is not me
1. I have an active lifestyle (play sports, work out, jog)…….			
2. I experience watery/red/burning eyes, eye allergies or work in an environment that is hard on my eyes……...			
3. I spend a lot of time outdoors in the sun or driving……			
4. I work on a computer more than 4 hours per day…..….			
5. I am required to wear safety glasses at work……			
6. I would like to change or highlight my eye color……...			
7. I sleep or nap in my contacts, or would like to……..			

8. Which of the following hobbies and leisure activities are important to you?

☐ Reading ☐ Golf ☐ Sewing ☐ Music ☐ Computer ☐ Gardening ☐ Fishing ☐ Tennis
☐ Running ☐ Hunting/Shooting ☐ Other _____

9. Describe how you use your vision at work _____

Are you interested in LASIK surgery? ☐ YES ☐ NO

Valley View Vision
Notice of Privacy Acknowledgement

Notice of Receipt

By signing this form, you acknowledge having received the "Notice of Privacy Practices" for Jessica P. Graham, O.D.

Patient Name: _____

Patient/Guardian Signature:  _____ Date: _____

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Financial Policy and Agreement

Thank you for choosing us as your eye care provider. We are committed to excellent patient care. The following is an explanation of our Financial Policy and Agreement which you must read and sign prior to any current and future evaluations or treatment in this office.

1. Each patient is responsible for their own bill.
2. Payment of all insurance co-payments and deductibles are required at the time services are rendered.
3. Patients who have no insurance are required to pay 100% of services rendered each visit. If this is impossible, you will need to make payment arrangements with our office manager prior to any evaluation or treatment. We accept cash, checks and Visa/MasterCard/American Express/Discover.
4. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. Your bill is your responsibility whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.
5. You are responsible for knowing what your insurance covers and the providers and network(s) covered under your insurance plan. Any services provided, but not covered by your insurance company, will be your financial responsibility.
6. If your insurance company has not paid your full account within 60 days, the outstanding balance must be paid by you without further delay.
7. Monthly payments are required on all accounts with outstanding balances. A monthly finance charge of 1 3/4% per month (21% annual rate) will be charged to the amount not paid after 60 days, with a minimum charge of $.50 per month. By signing below you acknowledge receipt of this Financial Policy and Agreement. If collection is made by suit or otherwise, patient and/or responsible party agrees to pay interest until paid, collection costs of 50% of the remaining balance, all attorney fees and court costs.
8. A $15.00 fee will be charged on all returned checks.
9. Glasses and/or contact lenses will not be dispensed until payment has been made in full.

USUAL AND CUSTOMARY RATES
Our rates for services reflect the usual and customary rates in the community. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates for services.

AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize this office to release all information concerning my medical treatment to my insurance carriers and to requesting referring providers (if any).

AUTHORIZATION TO PAY BENEFITS
I further direct said agency, attorney or insurance company to pay from the proceeds of benefits of any recovery or insurance payments in my case, directly to the provider of this office, for their professional services rendered. I understand this in no way relieves me from my personal responsibility for paying my provider when a statement is rendered. It is understood that signing this form does not prohibit customary monthly billings.

Patient/Guardian Signature:  _____ Date: _____