Name:_____ **Date:**_____

Main reason for visit today:

_____

_____

Medicines currently prescribed to you: (Or give list to staff)

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Have you been diagnosed with any of the following:

Diabetes ☐ Hypertension ☐ Glaucoma ☐ Macular degeneration ☐

Primary Care Physician: _____

Financial Policy

As a service to me, Mount Vernon Vision Source may request payment from my insurance company made on my behalf or on the behalf of my dependent (s). I understand and acknowledge that Mount Vernon Vision Source is not responsible for any incorrect or incomplete insurance information. Benefits quoted to me by Mount Vernon Vision Source or my insurance company is not a guarantee of payment. If my insurer denies coverage or Mount Vernon Vision Source does not receive payment within 45 days from filing the claim, the amount may then become due and payable by me.

I authorize payment to be made directly to Tod W. Jones, DBA Mount Vernon Vision Source, by my insurance company. **I understand that I am fully responsible for all services rendered and that payment of co-pay's, items not payable by insurance, and any co-insurance is due at the time of service.** Accepted forms of personal payment are cash, check, Visa, MasterCard, or American Express. There will be a $35 charge assessed on all returned checks. A service charge of 1.5% per month on all balances of sixty days or greater, with a minimum $5.00 late charge, will be assessed on your account.

Account Guarantor Signature _____ **Date** _____

Notice of Privacy Practices Good Faith Acknowledgement

By federal law, Mount Vernon Vision Source abides by the terms of HIPAA. By signing below, I acknowledge that a copy of Mount Vernon Vision Source's Notice of Privacy Practices is available to me at any time and will be provided if I so request.

Account Guarantor Signature _____ **Date** _____