Welcome to Advanced Vision Care of Victoria, P.A.
Notice of Privacy Practices

Patient Name: _____DOB_____ M___ or F___
If a Child, Parent or Guardians Name: _____
SS#_____E-Mail Address_____
Mailing Address_____
City_____State_____Zip_____
Daytime Phone _____Home _____Cell _____
Employer_____ Work Phone_____
Health Insurance Carrier_____
Vision Insurance Carrier_____

HITECH Act (The Health Information Technology for Economic and Clinical Health Act)
Due to the HITEC Act we are now reporting and are in compliance with US healthcare system through Electronic Medical Records. Please fill out the information below to help our office improve patient health care quality, increase patient safety, and efficiency.

RACE:
___American Indian or Alaska Native ___ Asian ___Black or African American
___Hispanic ___ Native Hawaiian or Pacific Islander ___ White

ETHNICITY:
___ Hispanic, Latino ___ Native Hawaiian, Pacific Islander ___ Not Hispanic or Latino

PREFERRED LANGUAGE:
___English ___ Spanish ___ Other: _____

COMMUNICATON PREFERENCE:
___Telephone ___ Email ___ Postal ___Text

MARITAL STATUS:
___Single ___ Married ___ Divorced ___ Widowed

EMPLOYMENT STATUS:
___ Full Time ___ Part Time ___ Unemployed ___Student
Occupation_____

HOW DID YOU HEAR ABOUT US:
___ Patient Referral:_____
___ Professional Referral:_____
____Yellow Pages ___ Web Site ___ Walk-In

I have Read and Understand the Notice of Privacy Practices.
Print Name_____

Signature_____Date_____

If you are signing as a personal representative of the patient other than a parent, describe your relationship to the patient and the source of your authority to sign this form:
Source of Authority_____

Print name_____

Signature_____Date_____

Initial_____ I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I understand that I am financially responsible for all charges whether or not paid by my insurance. Payment is due at the time services are rendered.