WELCOME

1 PATIENT INFORMATION

Patient _____

Address _____

_____

City State Zip

Home Phone _____ Cell Phone _____

Sex: ☐ M ☐ F Date of Birth _____

☐ Married ☐ Single ☐ Partnered ☐ Minor

☐ Separated ☐ Divorced ☐ Widowed

☐ Employed ☐ Full-Time Student ☐ Part-Time Student

Patient SS # _____

Occupation _____

Employer _____

Work Phone _____

Spouse's Name _____

SS # _____ DOB _____

Spouse's Employer _____

Additional Family Members

Name _____ DOB _____

Name _____ DOB _____

Name _____ DOB _____

Emergency Contact Name _____

Phone Number _____

2 INSURANCE/RESPONSIBLE PARTY

Name of Responsible Party _____

Address _____

Relationship to Patient _____

SS # _____ DOB _____

Primary Vision Insurance Co. _____

Subscriber Name _____

ID # _____ Group # _____

Relationship to Insured _____

Secondary Vision Insurance Co. _____

Subscriber Name _____

ID # _____ Group # _____

Relationship to Insured _____

Primary Medical Insurance Co. _____

Subscriber Name _____

ID # _____ Group # _____

Relationship to Insured _____

ASSIGNMENT AND RELEASE

I, the undersigned, assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. I hereby authorize the doctor to release all information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Responsible Party Signature Date

3 ACTIVITIES & SOCIAL HISTORY

Special Occupational Visual Needs _____

_____

Hobbies Sports

_____ _____

_____ _____

_____ _____

Are you interested in contact lenses? ☐ Yes ☐ No

ARE YOU INTERESTED IN LASER VISION CORRECTION?

☐ Yes ☐ No

Alcohol Use: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Tobacco Use: ☐ Never ☐ Yes ☐ Previous

4

*Whom may we thank for referring you to our office?

_____

☐ Signage ☐ Direct Mail ☐ Radio

☐ Internet ☐ Yellow Pages ☐ Newspaper

Please Sign Back

PATIENT SERVICE AGREEMENT

Thank you for choosing us as your eye health care provider. Prior to receiving care, read and sign the following.

OUR COMMITMENT TO YOU:

- Personalized Eye Health Care
- Patient Education
- Exceptional Service with Infinite Accuracy
- Controlling Costs

- Full payment is due at time of service.
- A minimum of half down is required at time of order with full payment when glasses and/or contact lenses are picked up.
- We accept cash, checks, credit cards.

INSURANCE

- Your insurance is a contract between you and your insurance company. We are not a party to that contract. We will pre-certify your coverage at the time of your visit. During pre-certification, every insurance company states, "This is not a guarantee of benefits".
- As a courtesy, we may accept assignment of insurance benefits and we will file your insurance claim for you. Be aware that some, perhaps all, of the services provided may be deemed non-covered services by your insurance company.
- If your insurance requires you to have a prior-authorization or referral, it is your responsibility to request and obtain the needed information. If you do not have one, treatment may be denied.
- The maximum we will wait for insurance reimbursement is 90 days, after which the insurance amount is then payable by you.
- Regarding insurance plans in which we are participating providers, all co-pays and deductibles are due the day service is provided, per your insurance company. You may lose privileges if you do not comply. If we are non-participating providers you are responsible for the balance.

USUAL AND CUSTOMARY RATES

- You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary fees.

MINOR PATIENTS

- The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment may be denied unless charges have been pre-authorized. It is not possible for us to do split billing between accounts.

INTEREST

- We reserve the right to charge a late fee in the amount of 1% as provided by state law for any unpaid patient balance remaining after 60 days of service.
- Collection proceedings will begin on any outstanding balance in non-compliance with this policy.

Signature of Responsible Party

Date