Welcome to Our Practice

Patient Name _____ **Date of Birth** _____ **Phone Number** _____

Primary Physician _____

PAYMENT IS DUE AT THE TIME OF SERVICE. If you request, we will provide you with all necessary information so you may file a claim with your insurance carrier for reimbursement. Payment is due at the time of service. If payment on balance is not paid within 25 days of the monthly billing date, a service charge of 1.5% per month will be added to the account. Accounts over 90 days are subject to collection. In the case of default of payment, I agree to pay any legal interest on the balance due, together with reasonable attorney fees incurred. A NSF Check fee in the amount of $25.00 will be charged for all returned checks.

NO SHOW POLICY: It is customary to give at least 24 hours notice prior to missing your scheduled appointment. Failure to do so may limit your options to schedule in the future. More than one offense will require a non-refundable prepayment in cash prior to scheduling.

PRIVATE INSURANCE: We will submit your claim and do our best to help you obtain benefits, but we cannot be responsible if your carrier does not pay. If we are Out of Network with your insurance company, we require payment in full at the time of service.

INSURANCE CONTRACTS: If we have a "Participating Contract" with your insurance carrier, we will accept assignment on all covered services and bill your carrier for you. You are responsible for the co-pay, coinsurance, and deductible and for all non-covered services at the time of service. **MEDICARE**: We accept Medicare Assignment. This means that we accept what Medicare allows for covered services. Medicare will usually pay 80% of the allowed charges, and the patient is responsible for the remaining 20% plus the annual deductible. Medicare will not pay for medically unnecessary services, such as routine examinations and refractions, (which determines the prescription for glasses). You are responsible for the co-pay, deductible and for all non-covered services at the time of service.

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION: I authorize the release of medical information necessary to process my claim and provide to my primary physician. I authorize payment of medical benefits to Eyecare Specialties for services rendered. **I have read and understand the policies described above. I authorize treatment and I acknowledge that I understand my out of pocket costs and I am responsible to pay all charges for treatment administered by Eyecare Specialties as outlined above.**

➤**Signature**_____ **Date**_____

I acknowledge that I was given the opportunity to receive a copy of this office's Notice of Privacy Practices. HIPAA

➤**Signature**_____ **Date**_____

I authorize Eyecare Specialties to disclose my medical records/protected health information (PHI) to:

Authorized Person _____ Phone #_____ Emergency Contact? **YES** **NO**

Relationship to Authorized person _____

Authorization Expiration Date_____ You have the option to set an expiration date for this authorization.

Records to be disclosed: ↺ Entire Record ↺ Medical Records Only ↺ Financial Records Only

➤**Signature of Responsible Party**: _____ Date: _____

IF PATIENT IS A MINOR, PLEASE PROVIDE THE FOLLOWING INFORMATION

If patient is a child: _____ _____
Mother Father

Responsible Party: _____ Relationship: _____

Address: _____ Social Security #: _____

Home Phone: _____ Work Phone: _____ Employer: _____

CONSENT FOR TREATMENT OF A MINOR: I hereby give consent for Eyecare Specialties to provide Optometric services to the minor patient.

➤**Signature of Responsible Party**: _____ Date: _____