Patient Information

Patient Name _____

First Name Middle Name Last Name Preferred Name

Date of Birth ___/___/_____ Social Security Number ____-_____-_____

Sex: Male: € Female: € Marital Status: Single € Married € Divorced € Widowed €

Address: _____

Apt. City State Zip Code

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Email Address (for possible contact): _____

Employer: _____ Occupation: _____

Preferred Language: English € Spanish € Other _____

The following information is optional and is being gathered to ensure that all patients receive the best care possible.

Race:	American Indian or Alaska Native	€	**Ethnicity:**	Hispanic	€
	Asian	€		Native Hawaiian /Other Pacific Island	€
	Black or African American	€		Not Hispanic or Latino	€
	Hispanic	€		Other	€
	Native Hawaiian / Other Pacific Island	€			
	White	€			

Do we have your permission to contact you by texting? Yes € No €

Guarantor Information (Person Responsible for Billing)

_____

First Name Middle Name Last Name Preferred Name

Date of Birth ___/___/_____ Social Security Number ____-_____-_____

Address: _____

Apt. City State Zip Code

Relationship to Patient: _____

Insurance Information

(Please fill out as completely as possible.)

Primary Vision Insurance: VSP € EyeMed € Other: _____

Policy Holder's Name: _____

Policy Holder's D.O.B.: ___/___/_____ Policy Holder's Social Security Number ____-_____-_____

Medical Insurance: Aetna ∈ Anthem BCBS ∈ Cigna ∈ Medicare ∈ UHC ∈ Other: _____

Policy Holder's Name: _____

Policy Holder's D.O.B.: ___/___/_____ Policy Holder's Social Security Number ____-_____-_____

Policy #: _____ Group #: _____

Copay: $_____ Deductible: $_____

Policy Holder's Employer: _____

Relationship to Patient: _____ Eligibility Date: ___/___/____

How did you hear about this practice? _____

Financial Policies (Insured and Non-Insured)

All service fees and co-payments are due when services are rendered. We will file claims for services rendered to the appropriate insurance payer in good faith. All medical eye care is subject to any insurance deductible. It is the patient's responsibility to know the specifics of the insurance plan and to pay any amounts applied to the patient deductible. Any unpaid balances that are left after 90 days will be subject to a monthly $5.00 late fee and additional service fee of up to 35% of your balance, if sent to collections. A minimum of 50% DOWN PAYMENT is required on all materials to start your order. Any balance will be due upon the dispensing of your eyewear. NO CASH REFUNDS ON MATERIALS. It is the patient's responsibility to provide correct insurance information at least 24 hours before the date of service. Our office does not submit claims retro-actively and does not change billing after the service date. Certain insurance plans require the patient to obtain a referral from the primary care physician before the appointment. In a case like this, we will provide services and attempt to reach out to your provider on your behalf for a referral. However, if we are unable to obtain a referral, a claim will be submitted to your insurance, and you may be responsible for the fees incurred from the visit.

CONTACT LENSES are medical devices requiring additional evaluation to ensure proper eye health, vision, and comfort. The fee for these services is not included in other eye care provided and varies with the contact lens type and complexity of the professional service. This fee starts at $84 and is most often not fully covered with vision insurance or other insurance plans. Fees for professional services are due in full on the service date and contact lens materials require a minimum 50% deposit to order. No contact lens prescription can be released until the lenses are finalized, which may require a mandatory follow-up visit. Please ask for any clarification needed about the policy on contact lens materials or services.

Insurance Authorization

I have read and understand the above policies and authorize payment of insurance benefits from Medicare, Medigap, or other insurance companies to be made on my behalf for any optometric services rendered. I also authorize Allisonville Eye Care Center, Inc. to release any information needed to the appropriate agency to determine any benefits and provide appropriate care.

SIGNATURE (RESPONSIBLE PARTY) _____ DATE _____/_____/_____

Printed Name of Responsible Party _____

Notice of Privacy Policy

By signing below, I indicate that I have received a copy of the Notice of Privacy Practices of Allisonville Eye Care Center, Inc. (This can be printed in advance from our website, www.all-eyes.org, or obtained upon arrival.)

SIGNATURE (RESPONSIBLE PARTY) _____ DATE _____/_____/_____