FINANCIAL POLICY

COPAYMENTS & DEDUCTIBLES Your insurance plan determines your copay/co-insurance/ deductible. Contact your insurance company to obtain co-pay, coinsurance/deductible information. All co-payments are due at the time of service.

A $5.00 service fee will be charged if the co-pay is not paid at the time of service.
A $35.00 service charge will be applied for each returned check.

Pt Initials _____

INSURANCE COVERAGE Understanding you insurance plan is your responsibility. Please contact your insurance company directly with any questions regarding your coverage. *It is simply not possible for our staff to know the details of every individual insurance plan.*

If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for payment of the services. Please notify our office of any changes to your insurance coverage. If your insurance coverage was not in effect at the time of your visit, you will be responsible for payment in full.

Pt Initials _____

MISSED APPOINTMENTS We kindly request a 24 hour notice to either cancel or reschedule an appointment. You may be charged a $25 fee if you do not provide 24 hour notice.

Pt Initials _____

PAYMENT POLICY Just as we make every effort to accommodate you for your eye care, we expect that you will make every effort to pay your bill promptly within 30 days. If you have a financial hardship or if you are unable to pay your bill in its entirely please contact our billing office to discuss payment options.

A $5.00 service fee will be charged for every 45 days an account is past due. If your account is 90 days past due and you have not established a payment arrangement with our billing office, your account will be turned over to a collection agency. A collection agency fee of 36% will be added to your account if turned over to agency.

Pt Initials _____

I have read the financial policy and agree to its terms

_____ _____

Patient Signature Date

PATIENT REGISTRATION

Name: _____

Address: _____City: _____State: __Zip: _____

Home #: _____ Work #: _____ Cell #:_____ Email: _____

Preferred method of contact for appointment reminders: _____

Date of Birth: _____Male: ___ Female: ___ Family Physician: _____

Employer: _____ Occupation: _____

Is visit related to a workplace injury ? Yes _____ No _____

How did you hear about our practice: _____ Referred by: _____

Reason for today's visit: _____

INSURANCE AND PAYMENT INFORMATION

Insurance: _____ Secondary Insurance: _____

Name of Insured: _____ Name of Insured: _____

Relationship: _____ DOB: _____ Relationship: _____ DOB: _____

If your insurance requires a referral, did you bring it with you? _____

Who is responsible for the payment of your fees?

Name: _____ Relationship: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

_____ _____

PATIENT SIGNATURE DATE

TODAY'S DATE _____

HOW DID YOUR HEAR ABOUT US?_____ DATE & LOCATION LAST EYE EXAM**:**_____

NAME**:**_____ DATE OF BIRTH: _____

MEDICAL HISTORY

	YES	NO		YES	NO
DIABETES	____	____	ARTHRITIS	____	____
HEART ATTACK	____	____	CANCER/TUMOR	____	____
HIGH BLOOD PRESSURE	____	____	THYROID DISEASE	____	____
STROKE/SHOCK	____	____	SEIZURES	____	____
PACEMAKER/DEFIBRILLATOR	____	____	BLOOD CLOTS	____	____
ASTHMA	____	____	BLEEDING DISORDER	____	____
EMPHYSEMA	____	____	TRANSFUSIONS	____	____
LIVER DISEASE/JAUNDICE	____	____	AIDS/HIV POSITIVE	____	____
STOMACH ULCER	____	____	KIDNEY STONES/DISEASE	____	____
PACEMAKER	____	____	**LATEX ALLERGY**	____	____

OTHER: _____

FAMILY HISTORY *AMONG BLOOD RELATIVES*

	YES	NO		YES	NO
GLAUCOMA	____	____	RETINAL DISEASE	____	____
CATARACTS	____	____	DIABETES	____	____
MACULAR DEGENERATION	____	____	HEART DISEASE	____	____
NIGHT BLINDNESS	____	____	BLEEDING DISORDER	____	____

SOCIAL HISTORY

	YES	NO	
DO YOU DRINK ALCOHOL?	____	____	HOW MUCH PER DAY? _____
DO YOU SMOKE?	____	____	HOW MUCH PER DAY? _____

LIST ALL ALLERGIES: _____

PLEASE LIST ALL ***EYE*** MEDICATIONS YOU ARE CURRENTLY USING: _____

_____

_____

PLEASE LIST ANY PREVIOUS EYE SURGERY:

1. _____
2. _____
3. _____

OTHER SURGICAL PROCEDURES:

1. _____
2. _____
3. _____

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING AND THE DOSE:

1)_____ 2)_____

3)_____ 4)_____

5)_____ 6)_____

7)_____ 8)_____

PHARMACY NAME AND ADDRESS: _____

PATIENT SIGNATURE: _____ ***TODAY'S DATE*** _____

EYE EXAM POLICY

ROUTINE EYE EXAMINATIONS A general screening of the overall health of your eyes with no medical problems or complaints.

MEDICAL EYE EXAMINATIONS An eye examination where you are being evaluated for and/or treated for a medical condition or symptom that you describe to our staff, or a condition that the doctor finds during the examination. Examples include the following: *headache, diabetes, eye irritation, dry eyes, allergies, floaters, contact lens intolerance, glaucoma, cataract, macular degeneration,etc*

VISION PLANS/VISION BENEFIT Typical coverage includes an eye examination and a pair of eyeglasses or contact lenses once every 12-24 months. The exam benefit is only used to update your eyeglass or contact lens prescription and not to treat any medical eye issue. If during your visit, the doctor identifies an eye problem, disease, or injury, your visit will be billed to your medical insurance. You will be able to use your routine benefit at a later date.

REFRACTION The refraction test provides the doctors information about the function of your eyes and may alert the doctors of any problems that may be related to a decrease in your vision. This test is also necessary if you wish to get an updated eyeglass or contact lens prescription. If you do not have routine exam coverage or a separate vision plan, there is a **$50.00** fee for this service, in addition to your copayment or other fees your insurance policy dictates. The fee is not covered under most insurance plans. If your insurance pays the fee, we will reimburse you accordingly.

Please check one:

- ☐ I do NOT have a separate Vision Plan or vision coverage through my medical insurance.
- ☐ I do have a separate vision plan
- ☐ I do have routine vision coverage through my medical plan

If I determine that I have vision coverage plan after my exam has been completed, the exam will not be able to be resubmitted to my vision coverage. _____

Patient initials

I understand that my symptoms and the doctor's findings during my exam will determine how my exam is billed to my insurance. I am responsible for any fees that my insurance does not cover. It is my responsibility to know the details of my plan, including deductibles, co-payments, and routine vision coverage.

_____ _____

Patient Signature Date