WELCOME TO OUR OFFICE

Patient Full Name _____ Nickname _____

Address _____ City _____ State_____ Zip Code _____

Phone Home (___)_____ Daytime (___)_____ Cell (___)_____

E-Mail _____ Male / Female

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

Marital Status _____ Spouse Name _____

Employer/ School _____ Occupation _____

Emergency Contact/ Relationship _____ Phone (___)_____

Responsible Party/ Insured

Full Name _____ Relationship to Patient _____

Address _____ City _____ State_____ Zip Code _____

Phone Home (___)_____ Daytime (___)_____ Cell (___)_____

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

Employer _____ Occupation _____

Insurance Company _____ ID# / Group # _____/_____

Who may we thank for referring you to our office? _____

Patient Responsibility – Due to Medicare and other insurance requirements, the following policy will be effective 06/01/11.

Refraction Charge

During your exam, you may receive refraction. Refraction is a test done to determine a prescription for new glasses. Refractions are not typically a covered expense by insurance companies. Medicare considers refractions to be "not medically necessary" and, therefore, does not cover refractions. Your insurance company may not consider refractions to be medically necessary, either. The cost of the refraction is $30.00. This amount will be in addition to the price of your exam and collected along with any applicable co-pays at the time of checkout.

Financial Waiver

In the event I do not have any insurance, my deductible has not been met, my insurance company does not pay in full or denies payment, I understand that I (Patient or Responsible Party) will be liable for all charges incurred. I understand if I have co-pays, overages or I do not have any insurance my charges will be due and payable at the time of service. There will be a $35.00 returned check fee.

Contact Lens Exam Cost

There is an additional charge for the contact lens examination. Most insurance companies do not cover contact lens related office visits, so I understand these charges will be my responsibility. The cost for contact lens evaluation and management services will depend on the kind of contact lens fitted.

Direct Payment and Medical Release Authorization

I authorize Medicare/Insurance to pay benefits directly to the Optometry Group for any services or material furnished. I authorize release of medical information needed to process my claims or to determine benefits to the Centers for Medicare Services and its agents. Furthermore, I authorize Medicare/Insurance to furnish to this office any information regarding my claims under Title VIII of the Social Security Act. A copy of this signature is as valid as the original.

Privacy Practices Acknowledgement of Receipt

I acknowledge that I have read or received a copy of the Optometry Group's Notice of Privacy Practices.

Signature _____ Date _____