<u>The Center for Eye Care and Optical</u>

Patient Registration Form

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Appt Date        Time    Provider
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Patient Information:

Patient Name: ____________________ Medical Record #: _________

Address: _______________________________________

Date of Birth: _____________ Gender: _____

Home Phone: ______________ Work Phone: ________________

Cell Phone: ______________________

Email Address: ________________________________

Race: __ American Indian / Alaskan Native __ Asian __ Native Hawaiian / Other Pacific Islander
__ Black / African American __ White __ Other Race

Ethnicity: __ Hispanic or Latino __ Non-Hispanic or Latino

Language: ___________________

Primary Care Physician: _________________ Endocrinologist *(if any)*: _____________________

How were you referred to our office? ____

Responsible Party Information:

Note -The financially responsible party can never be a child. If the patient is a minor, fill in responsible parent or guardian.

Is the responsible party the same as the patient: __ Yes __ No *(if no, please fill in the information below)*

Name: ______________________________

Address: ____
Date of Birth: __________________________ Gender: __ Female __ Male

Home Phone: ( ) ________________ Work Phone: ( ) ________________

Cell Phone: ( ) ________________ Email Address: _______________________________________

SSN: _________________________ Relationship: _________________________________

The Center for Eye Care and Optical

Medical Insurance Information:

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C INSURANCE CARRIER             INSURED             INSURED ID    GROUP
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Is Your Condition Related to: __ Employment __ Auto Accident

I acknowledge that the above information is complete and correct. I accept financial responsibility for any services rendered for my dependent or myself.

Signature: X____ **Date:** X____________________

The Center for Eye Care and Optical

Patient Financial Responsibility Form

Patient Name: ______________________ Date: ________________

Both the REFRACTION and the MEDICAL EYE EXAM are absolutely necessary to fully evaluate the health of your eyes and visual system. The only way we can sort out whether reduced vision is a matter of simple eyeglass adjustment or some other problem is to perform a REFRACTION.

Below are a list of some of the insurance companies that cover the REFRACTION

AETNA
UHC COMMUNITY PLAN
MEDICAID
HEALTHCARE PARTNERS
MARCH VISION
SPECTERA
DAVIS VISION
NVA
UFT
SOME BLUE CROSS AND BLUE SHIELD PLANS
SOME UNITED HEALTHCARE PLANS
SOME HIP PLANS
SOME EYEMED PLANS

The fee for the refraction is $65.00. Refraction fee for all other insurances will be collected at the time of the visit. If your insurance company is listed above, we will bill your insurance company first. If they do not pay for the refraction you will be billed.

Payment for the applicable co-payment(s), deductible(s), and non-covered services are due on the date of service. There will be an additional $25.00 charge If payment is not received at time of service.

If you cancel or no show an appointment 2 or more times without a 24 hour notice, there will be a charge of $50.00.

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy. We now offer the following payment options: (EXCLUDING REFRACTION)

__________ Payment by Cash, Check, or Credit Card

__________ Automatic Monthly Billing to your Credit Card

__________ PreAuth any amount not covered by insurance with your Credit Card (Deductible and Co-Insurance)

Please make your choice, sign below and return to reception before treatment. If none of the above apply, please ask to speak with a billing representative.

I I have spoken with a representative of this practice and understand fully that I am responsible for all amounts not covered by my insurance.

X __________________________
Patient Signature or Authorized Party

X ______________________
Date

The Center for Eye Care and Optical

Signature on File, Assignment of Benefits, Financial Agreement

BENEFICIARY NAME: **Account #**

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to The Center for Eye Care and Optical for services furnished me by The Center for Eye Care and Optical. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. The Center for Eye Care and Optical accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to The Center for Eye Care and Optical, if possible or otherwise to me.

3. RELEASE OF INFORMATION: The Center for Eye Care and Optical may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to The Center for Eye Care and Optical for reimbursement for services rendered, and (2) any health care provider for continued patient care. The Center for Eye Care and Optical may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. OTHER INSURANCE: I understand that The Center for Eye Care and Optical maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that The Center for Eye Care and Optical has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by The Center for Eye Care and Optical if I belong to a plan that does not appear on the above mentioned list.

5. NON-COVERED SERVICES: I understand that The Center for Eye Care and Optical contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patients contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with The Center for Eye Care and Optical to obtain necessary health care service plan authorizations.

6. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by The Center for Eye Care and Optical, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to The Center for Eye Care and Optical for payment. If an account is sent to an attorney for collection, I understand that if my account is deliquent I agree to pay collection expenses which are curently 30% of all outstanding fees as well as the reasonable attorneys fees as established by the court and not by a jury in any court action. Any benefits of any type under any policy of insurance, insuring the patient, or any other party liable to the patient, is hereby assigned to The Center for Eye Care and Optical. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to The Center for Eye Care and Optical. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.*

X ______________________________ **X** ______________

Patient Signature or Authorized Party Date

The Center for Eye Care and Optical

Receipt of Notice of Privacy Practices Written Acknowledgement

I, ________________have reviewed a copy of The Center for Eye Care and Opticals Notice of Privacy Practices.

Express Authorization for the Disclosure of Protected Health Information

I have been advised of my rights to obtain access and control my Protected Health Information (PHI). I also understand that in providing treatment, submitting billing and conducting healthcare operations The Center for Eye Care and Optical may need to disclose my PHI to certain third parties.

By providing the requested information below, I further authorize the disclosure of my PHI as follows:

If I am unavailable, I expressly permit The Center for Eye Care and Optical to disclose my PHI to the following individuals:

____ ______________________________
(Relationship to me)

____ ______________________________
(Relationship to me)

____ ______________________________
(Relationship to me)

- OR -

______ **Do not disclose my protected health information to any individuals.**

X____ **X**______________________________
Patient Signature or Authorized Party Date