

EYE PHYSICIANS & SURGEONS, P.C.

NEW PATIENT REGISTRATION & INSURANCE INFORMATION

PATIENT INFORMATION

Legal Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt. \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: M / F Marital Status: \_\_\_\_\_

Email Address: \_\_\_\_\_

RESPONSIBLE PARTY (Complete if patient is a minor or another person is financially responsible)

Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt. \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_

PAYMENT & INSURANCE INFORMATION

Accepted Payment Method: ☐ Cash ☐ Credit Card ☐ CareCredit ☐ Insurance

How did you hear about our practice? \_\_\_\_\_

Referring/Primary Care Physician: Dr. \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Please present your current insurance card(s) and photo identification at each visit.

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS

I authorize Eye Physicians & Surgeons, P.C. to release information necessary to process my insurance claims and to communicate with my insurance carrier as permitted by law. I authorize payment of medical benefits directly to Eye Physicians & Surgeons, P.C. for services provided. I understand that insurance authorization or claim submission does not guarantee payment and that I am financially responsible for amounts not paid by my insurance plan, subject to applicable law and contractual obligations.

Signature of Patient/Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

# EYE PHYSICIANS & SURGEONS, P.C.

## REFRACTION SERVICE AND FEE

### Simplified Patient Explanation

There are two types of insurance that may help pay for eye care: medical insurance and vision insurance. They generally cannot be billed for the same examination. The findings from your examination will help determine which insurance is billed first.

#### MEDICAL INSURANCE

Medical insurance pays for care related to medical eye conditions such as cataracts, glaucoma, dry eye, macular degeneration, and other diagnosed eye diseases. If your doctor identifies a medical condition during the examination, your medical insurance will be billed first.

#### VISION INSURANCE

Vision insurance generally covers routine eye examinations and may help with glasses or contact lenses. A refraction is the test used to determine your eyeglass or contact lens prescription. Medicare and many medical insurance plans do not pay for refraction. Some vision plans may cover this service.

#### HOW BILLING WORKS

- During your visit, your doctor will evaluate the health of your eyes.
- If a medical condition is identified, we will bill your medical insurance.
- If you also need an eyeglass or contact lens prescription, the refraction fee may be due at the time of service.
- If your vision plan covers the refraction and payment is later received, the practice may refund the applicable amount.
- If no medical condition is identified, your vision plan may be billed when appropriate.

#### PATIENT ACKNOWLEDGMENT

I have read and understand the information above. I understand that refraction may not be a covered service and that I am financially responsible for the fee when it is not covered. The refraction fee is \$50.00 and is due at the time of service. I understand that I am not required to purchase glasses, contact lenses, or other optical products from Eye Physicians & Surgeons, P.C. and may take my prescription to an optical store of my choice.

Patient/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

# EYE PHYSICIANS & SURGEONS, P.C.

## FINANCIAL POLICY

Our goal is to make your insurance and financial arrangements as clear and efficient as possible. Please review this policy carefully. Your signature confirms that you understand and accept these terms.

- You are ultimately responsible for payment for services you receive from our office, subject to applicable insurance contracts and law.
- Copayments, coinsurance, deductibles, and non-covered services are collected at the time of service.
- Certain procedures are non-covered services under some insurance policies. Payment for non-covered services is required at the time of service unless approved payment arrangements have been made. Refraction (CPT 92015) is one example and is generally considered routine eye care and may not be covered by medical insurance.
- We will process and submit health insurance claims for services provided. Insurance submission does not guarantee payment.
- You are responsible for providing current address, telephone number, email address, and insurance information at each visit. Failure to provide accurate information may result in nonpayment by your insurance carrier and may leave you responsible for the balance, subject to applicable law and payer contracts.
- Accepted payment methods are cash, credit card, and CareCredit. Eye Physicians & Surgeons, P.C., do not accept personal or business checks.
- Unpaid accounts may be referred to an outside collection agency, and you may be responsible for additional fees when permitted by law.
- Cancellation Fee: We require at least 24 hours' notice to cancel an appointment. Failure to provide the required notice may result in a \$50 cancellation fee that must be paid before rescheduling.
- No-Show Policy: If two appointments result in no-shows, a third appointment may not be rescheduled, and the cancellation fee may apply.
- Completion of Forms: A fee may be charged for completion of forms such as disability, FMLA, ADA, school, camp, or adoption forms. The fee must be paid before forms are completed. Fees vary depending on the time required.
- Copies of Medical Records: Fees for copying medical records are based on current applicable guidelines. A valid authorization may be required. Applicable retrieval and copying fees must be paid before a request is processed.

I acknowledge that I have read, understand, and accept this Financial Policy.

\_\_\_\_\_  
Signature of Patient/Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient (if minor)

\_\_\_\_\_  
Print Name

# EYE PHYSICIANS & SURGEONS, P.C.

## PATIENT DEMOGRAPHIC REGISTRATION

Please complete the information below. This information supports accurate patient registration, communication, and demographic reporting.

Patient Full Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_ Suffix \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Email Address: \_\_\_\_\_

### PREFERRED METHOD OF COMMUNICATION

☐ Home Phone: \_\_\_\_\_ ☐ Mobile Phone: \_\_\_\_\_

☐ Work Phone: \_\_\_\_\_ ☐ Other Phone: \_\_\_\_\_

☐ Email ☐ Secure Email ☐ U.S. Mail

### ETHNICITY

☐ Hispanic ☐ non-Hispanic ☐ Unknown ☐ Decline to Answer

### RACE

☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American

☐ Native Hawaiian/Other Pacific Islander ☐ White/Caucasian ☐ Decline to Answer

### PRIMARY/PREFERRED LANGUAGE

☐ English ☐ Spanish ☐ French ☐ Korean ☐ Chinese ☐ Arabic ☐ Other: \_\_\_\_\_

Signature of Patient/Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## EYE PHYSICIANS & SURGEONS, P.C.

### PATIENT ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I understand that my health information is private and confidential. I understand that Eye Physicians & Surgeons, P.C. work to protect the privacy and confidentiality of patient health information. I understand that the practice may use and disclose my health information for treatment, payment, and health care operations, and as otherwise permitted or required by law. I understand that additional information about the practice's privacy policies is contained in its Notice of Privacy Practices and that I have been given the opportunity to review a current copy.

#### PERSONS WITH WHOM WE MAY DISCUSS YOUR HEALTH INFORMATION

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

May we contact the person(s) above in case of emergency? ☐ Yes ☐ No

My signature below acknowledges that I have been given the opportunity to review the Notice of Privacy Practices and authorizes discussion of my health information with the individual(s) listed above, as indicated.

Signature of Patient/Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

#### PHARMACY INFORMATION

This information is used for new and refill prescriptions and for electronic prescribing.

Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

If you do not know the exact address, please provide the street name and city. The pharmacy may be located using its phone number.