

EYE CARE CENTERS

PATIENT ACCOUNT NO. _____

DATE _____

PATIENT NAME: Last First Middle Name Called By

IF UNDER 18 YRS. OLD: Name of adult with the patient. (Photo ID required) Relationship Phone number

1. A PICTURE IDENTIFICATION IS REQUIRED WITH A COPY OF INSURANCE CARDS.
2. PAYMENT WILL BE REQUIRED IN FULL **TODAY** IF A CURRENT COPY OF YOUR INSURANCE CARDS ARE NOT PROVIDED.
3. ALL CO-PAYS ARE DUE THE SAME DAY OF TREATMENT.
4. We will file insurance, including Medicare and Medicaid, according to plan requirements. We will assist in verifying your insurance coverage, however, while we are pleased to be able to provide this service to you, it is extremely difficult for us to know all the individual requirements of the plans. Therefore, it is your responsibility, as the patient/insured, to be aware of the current terms of your insurance coverage. Please read our financial and managed care insurer policies on the back of this sheet.

PATIENT INFORMATION:

Street Address Apt. # City State Zip

P.O. BOX City State Zip

Home Telephone () Ext. May we leave a message for you? Yes No

Work Telephone () Ext. May we call you at work? Yes No

E-mail Address Cell phone

Social Security No. Date of Birth Age Sex: M F Marital Status: S M D W

BILLING INFORMATION:

1. Person Responsible for Payment: Self Parent Guardian Other (Relationship) _____
2. Method of Payment: Check Cash Credit/Debit Card Insurance Workers Compensation
3. Please complete if the responsible person or policyholder is other than the patient:

Last Name First Middle Relationship to Patient

Street Address Apt. # City State Zip

SSN Date of Birth / / Home Telephone () May we leave a message?

Employer: Work Telephone () May we call you at work?

Street Address: City State Zip

REFERRAL:

Who may we thank for referring you to us? _____

EMERGENCY CONTACT:

Name Relationship Home Telephone Work Telephone

Complete Address

SIGNATURES REQUIRED:

1. Read and Sign the back of this sheet
2. Read and Sign the attached Summary of Privacy Practices

Eye Care Centers

FINANCIAL AND MANAGED CARE POLICIES

PAYMENT FOR SERVICES IS DUE IN FULL TODAY

The Eye Care Centers participate with many insurance plans as a convenience to our patients. However, we expect patients to pay their share for our services, as specified in your benefits contract. We will help you determine these amounts.

1. Payment of coinsurance, deductibles, co-pay or private pay is due at the time of service.
2. **Medicare Coverage:** I acknowledge that I may be responsible for certain charges on this or any related claim due to either the provisions of Medicare or lack of Medicare's policy to cover these charges. I understand Medicare MAY NOT pay for particular items and services. I am fully responsible for non-coverage.
3. **Commercial Coverage:** I acknowledge that I may be responsible for certain charges on this or any related claim due to either the provisions of my insurance or insurance policy to cover these charges. I understand my insurance MAY NOT pay for particular items and services. I am fully responsible for non-coverage.
4. **Private Pay:** I understand payment is due in full at the time of service.
5. I understand I can appeal my insurance's payment decision (Commercial or Medicare).

I understand that any financial responsibility on my behalf is to be resolved at the time of service.

Signature: _____ Date: _____

SIGNATURE AND INFORMATION UPDATE

You may sign below up to **three years** to acknowledge updated information.

IF there has been **No** change in your home address, home phone, work information or insurance coverages as listed in our system.

I have read the information listed on the reverse of this sheet and to the best of my knowledge all information is accurate. I acknowledge that I may be responsible for certain charges on this or any related claim due to either the provisions of my insurance contract or lack of an insurance policy to cover these charges. I understand that any Financial responsibility on my behalf if to be resolved at the time of service.

1. FIRST YEAR Signature of patient or Responsible Person: _____ Date: _____

2. SECOND YEAR Signature of patient or Responsible Person: _____ Date: _____

3. THIRD YEAR Signature of patient or Responsible Person: _____ Date: _____

4. FOURTH YEAR Signature of patient or Responsible Person: _____ Date: _____