

# WELCOME TO THE EYE CENTER

## PATIENT INFORMATION

Mr.  Mrs.  Ms.  Miss  Dr.  Married  Single  Divorced  Widowed

Patient's Name \_\_\_\_\_ SSN \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
First Middle Last (Necessary for filing all insurances)

Street Address / Mailing Address \_\_\_\_\_ Date of Birth \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Home Phone Number

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Work Phone Number

(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-Mail Address  
Cell Phone Number

Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Spouse's Work Phone Number

\* IF UNDER 18 YEARS OF AGE: \_\_\_\_\_ Legal Guardian Name \_\_\_\_\_ Grade in School \_\_\_\_\_ Name of School \_\_\_\_\_

## BILLPAYER / RESPONSIBLE PARTY - Vision Insurance or Medical Insurance? Yes No

Billpayer's Full Legal Name \_\_\_\_\_ Billpayer's Date of Birth \_\_\_\_\_ Billpayer's Social Security \_\_\_\_\_

(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Billpayer's Place of Employment  
Billpayer's Work Phone

## WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?

Another patient? \_\_\_\_\_  Another doctor? \_\_\_\_\_

Telephone ad  Radio  Newspaper ad  Location

Other? \_\_\_\_\_

## PAYMENT POLICY - Please read carefully

### We will need a copy of your insurance cards!

Please let us know what insurance you have so that we can determine if we are providers prior to your examination.

### Fees for professional services are due when services are rendered.

When materials are necessary, glasses or contact lenses, at least half of the total fee is required to place the order. The balance will be due upon delivery.

Should your account become delinquent, and require legal collection efforts on behalf of our collection agency or settlement via small claims court, a "delinquent account fee" will be added to your account balance.

**The "Delinquent Account Fee" is \$50.00**

**The "Returned Check Fee" is \$25.00**

**We are happy to accept Visa, MasterCard and Discover!**

**I have read, understand and agree to the above terms and understand that I am responsible for any fees incurred.**

**X** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Patient / Billpayer Signature Date

## INSURANCE SIGNATURE ON FILE - Long Term Authorization

I request payment of authorized Medicare and /or Major Medical and/or Vision benefits be made on my behalf to Drs. Ward and Hall for any services furnished me by these Optometric Physicians. I authorize any holder of Medicare, Major Medical or Vision information about me to release to the Health Care Financing Administration and it's agents, or my private insurer (major medical or vision) any information needed to determine these benefits are payable for related services.

**X** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Patient / Billpayer Signature Date

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY

I acknowledge that I received a copy of the "Notice of Privacy Practices" for The Eye Center

**X** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Patient / Billpayer Signature Date

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Medicare # (HICN)

*We must have a copy of all of your insurance cards, including Medicare (red, white and blue card) and Medicaid (blue and white card).*

**ADVANCE BENEFICIARY NOTICE THAT MEDICARE WILL NOT PAY (ABN)**

**There are items and/or services, for which Medicare will not pay:**

- Medicare does NOT pay for all of your health care costs. Medicare only pays for covered benefits. Some items and services are not Medicare benefits and Medicare will not pay for them.
- When you receive an item or service that is not a Medicare benefit, you are responsible to pay for it, personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself.

Before you make a decision, you should read this entire notice carefully.

Ask us to explain, if you don't understand why Medicare won't pay, and ask us how much these items or services will cost you.

(Estimated cost to you: \$\_\_\_\_\_)

**MEDICARE WILL NOT PAY FOR:** \_\_\_\_\_  
(CPT-Code \_\_\_\_\_)

- Because it does not meet the definition of any Medicare Service.
- Because of the following exclusion\* from Medicare benefits:
  - Personal Comfort Items:
    - Luxury Frame
    - Progressive (no-line) Lenses
    - Tints
    - Anti-Scratch Coating
    - Photochromic Lenses
    - Sunglasses
  - Routine physicals and most tests for screenings
  - Routine eye care, eyeglasses and examinations for glasses
  - Paid for by a government entity that is not Medicare
  - Services by immediate relatives
  - Services required as a result of war

*\*Note: This is only a general summary of exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations and rulings.*

**I consent to the specified service and understand that I will be responsible for the estimated cost of the service.**

**X** \_\_\_\_\_  
Patient / Billpayer Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Today's Date