EYECARE SPECIALISTS

PATIENT INFORMATION

Name:_____ ☐ **Male** ☐ **Female** **Date of Birth** _____

Address:_____
No. Street City State Zip

Home_____ OK to leave voicemail ☐ **Cell Phone**_____ OK to Text ☐

Email Address:_____**Referred By:**_____

Primary Care Doctor Name:_____**City**_____
Telephone Number:_____

Emergency Contact

Name:_____ **Relation**_____

☐ **Tel #**_____

Insured Policy Holder Name (if not self)

Persons Name:_____ **DOB**_____

Financially Responsible Party

☐ **Self** ☐ **Other** (If minor under 18 years of age)

Name:_____**DOB**_____

Address:_____
No. Street City State Zip

Relationship to Patient_____ ☐ **Home** ☐ **Cell phone**_____

Preferred Pharmacy

Name:_____**Street:**_____**City**_____**State**____

Patient or Guardian's Signature_____**Date**_____

Turn over to sign⟶

EYECARE SPECIALISTS

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

I understand that by signing this form, I have read and I agree to the HIPAA Privacy Authorization Form and it will remain in effect for this and all future visits/treatments with Eye Care Specialists.

_____ _____

Signature of Patient or Legal Guardian **Date**

If you would like us to release medical information on your behalf to other family members, please ask Front Desk for the form

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Acknowledgement of Patient Financial Responsibility

I understand that by signing this form, I have read and I agree to Eye Care Specialists, P.C. Patient Financial Policy. By signing this form, I understand I am responsible only for the copayment, deductible, coinsurance, noncovered services, and any patient responsibility. I understand that by signing this form, it will remain in effect for this and all future visits/treatments with Eye Care Specialists, P.C.

_____ _____

Signature of Patient or Legal Guardian **Date**

NOTICE OF NON-COVERED REFRACTION SERVICES TO PATIENTS

I understand that by signing this form, I have read the form and I agree that: the refraction may not be a covered service under my health insurance plan. I agree to pay any fees related to this non-covered service along with any other fees required by my insurance plans (copayments/deductibles).

As of January 12, 2022, our refraction fee is $45.

_____ _____

Signature of Patient or Legal Guardian **Date**

EYECARE SPECIALISTS

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. I authorize Eye Care Specialists to use and disclose the protected health information, to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.
2. This authorization for release of information covers the period of healthcare from: all past, present and future periods.
3. I authorize the release of my complete health record, including records relating to mental healthcare, communicable diseases, HIV or AIDs, and treatment of alcohol or drug abuse
4. I understand that I have the right to revoke this authorization in writing at any time. I understand that revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
6. I hereby acknowledge that I received a copy of Notice of Privacy Practices.

I understand that by signing this form, it will remain in effect for this and all future visits/treatments with Eye Care Specialists.

EYECARE SPECIALISTS

Acknowledgement of Patient Financial Responsibility

I have received, read, understood, and hereby agree to the Eye Care Specialists, P.C. **Patient Financial Policy as stated below.**

I understand that charges not covered by my insurance plan, as well as applicable copayments and deductibles, are my responsibility.

I understand that Eye Care Specialists, P.C. 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 Eye Care Specialists, P.C. has no contract, expressed or implied, with any plan that does not appear on the list. I understand that I am individually obligated to pay the full charges of all services rendered to me by Eye Care Specialists, P.C. if I belong to a plan that does not appear on the above mentioned list.

I understand that repeated missed appointments may result in my inability to make future appointments.

I understand that it is my responsibility to be familiar with my insurance plan and what benefits it provides. This includes what copayment and deductible amounts are and when I need to obtain referrals and authorizations prior to treatment.

I authorize my insurance plan to assign and/or pay benefits directly to Eye Care Specialists, P.C.

I authorize Eye Care Specialists, P.C. to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

I understand that my bills need to be paid to Eye Care Specialists, P.C. within 60 days.

I understand that if my account is past due after 60 days that my account may be referred to a collection agency if I have not set up a scheduled payment plan.

I am responsible for all costs incurred/associated with the collection of any amount past due to Eye Care Specialists, P.C.

I understand that if I do not have insurance coverage (***self-pay***) that I am responsible for payment in full of all charges associated to my treatment at Eye Care Specialists, P.C.

I understand by signing this form, it will remain in effect for this and all future visits/treatments with Eye Care Specialists.

EYECARE SPECIALISTS

NOTICE OF NON-COVERED REFRACTION SERVICES TO PATIENTS

Definition of **REFRACTION**: The refraction test is an eye examination that measures a person's ability to see an object at a specific distance. Your eye doctor can determine if you have any visual conditions and help confirm the extent of vision difficulty, and can determine if a person has normal vision. When a person complains of blurry vision, this test can help determine the extent of poor vision. It can also be performed to help follow the progress of treatments for diseases of the eye such as cataracts. The test is also used to prescribe glasses if needed, and ensure the prescription for eyeglasses or contact lenses to be correct for each patient.

Medicare and most commercial insurance plans do not cover this service. If your eye doctor determines that you will need to have a refraction performed and your insurance does not cover it, you will be held responsible for paying that portion of the exam fees along with any other charges you are normally responsible for (copayments/deductibles). Our refraction fee as of January 12, 2022 is $45.

By signing, I understand that the refraction may not be a covered service under my health insurance plan. I agree to pay any fees related to this non-covered service along with any other fees required by my insurance plans (copayments/deductibles).