CONFIDENTIAL

PATIENT INFORMATION

Thank you for choosing our practice for your eyecare needs. Please fill out this form as completely as you can using an ink pen. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help.

(Please Print) Have you been examined by one of our Doctors before? ☐ Yes ☐ No

☐ Mr. ☐ Mrs. ☐ Ms.
☐ Miss ☐ Dr. ☐ Fr. ☐ Sr. Name____________________ Nickname____________________
FIRST MI LAST

Address____________________ City____________________ State__________ Zip__________

Home Phone #__________ Daytime Phone #__________ Cell Phone #__________ Pager #__________ FAX #__________

E-mail:__________ Gender: ☐ Male ☐ Female Birthdate____/____/____ Age_____ Social Security #__________

Are you: ☐ Minor (Under age 18) ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated

Employer____________________ Occupation____________________

VERY IMPORTANT! If this is your **FIRST VISIT** to this office: WHO MAY WE THANK FOR REFERRING YOU?

Name of person who referred you____________________

How do you know this person? ☐ Friend ☐ Relative ☐ Another Doctor ☐ Insurance Company ☐ Other

If not referred, how did you choose our office? ☐ On Insurance Co. provider list

☐ Phonebook/Yellowpages ☐ Saw sign/building ☐ Other____________________

RESPONSIBLE PARTY

Who is the Adult responsible for this account: ☐ Self ☐ Other (fill in below):

Name of person responsible for this account____________________

Address____________________ City____________________ State__________ Zip__________

Home Phone #__________ Daytime Phone #__________ Social Security #__________

Employer____________________ Gender: ☐ Male ☐ Female Birthdate____/____/____

INSURANCE INFORMATION

Do you have insurance that covers **VISION** care? ☐ Yes ☐ No

Do you have insurance that covers **MEDICAL** care? ☐ Yes ☐ No

If yes, please give your insurance card/information to the receptionist so that we can get an authorization to provide services from your insurance company.

Signature on File, Assignment of Benefits, Financial Agreement

And

Notice of Privacy Practices

______________________________________ ______________________________

Beneficiary Name (*print*) Medicare Number or Social Security Number

1**. MEDICARE**: I request that payment of authorized Medicare benefits be made on my behalf to **UNIVERSITY VISION CENTRE** for services furnished me by **UNIVERSITY VISION CENTRE.** 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. **UNIVERSITY VISION CENTRE** 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 **UNIVERSITY VISION CENTRE**, if possible or otherwise to me.

3. **OTHER INSURANCE**: I understand that **UNIVERSITY VISION CENTRE** 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 **UNIVERSITY VISION CENTRE** 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 **UNIVERSITY VISION CENTRE** if I belong to a plan that does not appear on the above mentioned list.

4. **NON-COVERED SERVICES**: I understand that **UNIVERSITY VISION CENTRE**'**s** contracts with health care service plans (i.e., HMOs, PPO5) 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 patient's 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 **UNIVERSITY VISION CENTRE** to obtain necessary health care service plan authorizations.

5. **FINANCIAL AGREEMENT**: As a courtesy, we are happy to assist you in filing your insurance claim. We will file one claim on your behalf. If your insurance company pays you directly or denies your claim, we ask that you pay the balance. We will allow a **maximum** of 90 days for the insurance payment to arrive. If we have not received payment within 90 days, we ask that you pay the balance. Our office policy calls for payment at the time of service. If eyewear or contact lenses are to be ordered, a minimum 50% deposit is requested and the balance is due upon delivery. We accept cash, personal checks, and all major credit cards. A monthly rebilling fee of $5.00 is added to all accounts with unpaid balances 30 days after bills have been sent. I agree that in return for the services provided to the patient by **UNIVERSITY VISION CENTRE**, I will pay my account at the time service is rendered. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest and/or late fees at the legal rate. 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 **UNIVERSITY VISION CENTRE**. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to **UNIVERSITY VISION CENTRE**. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.*

6**. NOTICE OF PRIVACY PRACTICES**: I acknowledge that I have been provided with a copy of the Notice of Privacy Practices.

I have read, understand, and agree to all the provisions discussed in the paragraphs above

____ ______________________

Beneficiary Signature or Authorized Party Date