Vision Institute

Today's Date: ________/_________/__________ Nick Name: ____

Last Name: ____ First Name: __________________________________ MI: ______

Sex: **Male** or **Female** (Please Circle) SS# (Needed for insurance billing):_____________-_________-______________

Primary Language: _________________________ Race: ______________________ Ethnicity: _________________________

Birthdate: ________/________/_________ Current Age: ___________ E Mail Address: _________________________________

Mailing Address: ____Apt:_____________________

City: ____ State: ______ Zip: __________

Preferred Pharmacy:____

Cell Phone #: ( ) ______-____________ Home Phone #: ( ) ______-___________ Work Phone # ( ) ____-_____________

May we leave voicemail on: Cell: Yes______ No: _____ Home: Yes: _____ No: _____

Married: _____ Partnered: _____ Single: ______ Separated: _____ Divorced: ____ Widowed: _____ Minor: ______

Patient's Primary Care Physician: ____

Insurance Information: *(Even though we have scanned your insurance cards, we require that you still fill this out.)*

Person responsible for this account: ____________________________________ Relationship to patient: _____________

Person responsible for account date of birth: _________________Primary Holder SS#: _________-_______-__________

Primary Insurance Company: _________________________ ID #: _______________________GRP #: _________________

Secondary Insurance Company: _________________________ ID #: _________________________ GRP #: ______________

Vision Plan Insurance Company: ____

Assignment and Release

I certify that I, and/or my dependents have insurance coverage with ________________________________ and assign directly to Vision Institute/Simmons Eye Associates, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that **I am financially responsible for all charges whether or not paid by insurance**. I authorize the use of my signature on all insurance submissions. The above named clinic may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or three years from the date signed below. If you have **MEDICARE**: I request that payment of authorized Medicare benefits and, if applicable, Medicaid/Secondary Insurance benefits, be made on my behalf to Vision Institute/Simmons Eye Associates, PC for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me, to release to the centers for Medicare/Medicaid/Secondary services and their agents, any information needed to determine these benefits or benefits for related services.

Print Name: _________________________Signature: _______________________________Date: _____/______/________

Patient Financial Responsibility Contract

Please read, initial each blank and sign where indicated- this document describes your financial responsibilities.

____ (initial) I agree to be financially responsible for payment of Vision Institute services. Cash, check or credit card are acceptable forms of payment for these services.

____ (initial) I agree to give Vision Institute current, complete and accurate primary and secondary Insurance information at each visit including up to date copy of your insurance card, completed patient information sheet, and referral documents from other providers, if needed. These documents must be updated on an annual basis and/or whenever there is a change. In the event that Vision Institute cannot validate active coverage with my insurance carrier, my account will be considered self-pay.

____ (initial) I understand Vision institute will bill my insurance company for services provided and if I fail to provide this information it may result in a denial of my claim or a delay in payment.

____ (initial) I understand that I am ultimately responsible for any charges not paid by my insurance company and I am responsible for any balance on my claim immediately upon receipt of a statement.

____ (initial) I understand that if I fail to pay the balance on account, this may result in Vision Institute pursuing any collection means possible.

____ (initial) I understand that if my insurance benefit requires me to provide a referral and if the referral is not in place before my appointment, I will have a payment plan in place or reschedule my appointment.

____ (initial) I understand Vision Institute has a contract with my insurance company and will receive payments from my insurance company for covered services provided by my insurance benefits. I agree to pay co-payments, co-insurance and deductibles at time of service.

____ (initial) I understand that I will be responsible for any missed appointments or any cancelled appointments in which a 24 hour notice was not given. There will be a fee of $35 for any missed office visits, $50 for any missed office procedures and $250 for missed surgery appointments.

____ (initial) I understand there will be a fee for all returned checks.

____ (initial) I understand if my account becomes delinquent, it may be forwarded to an outside collection agency without notice. Vision Institute reserves the right to make a “Demand for Payment”. If this happens, I will be responsible for all cost of collections, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency cost.

____ (initial) I understand if the reason for my appointment is related to a work injury or auto accident, I agree to give Vision Institute the case number or policy number, the workman’s compensation or insurance carrier’s name, address or other contact information at the time of my visit. If I do not provide this information at the time of the visit, I agree to pay all charges for my visit.

Patient Financial Responsibility Contract Continued

Please read, initial each blank and sign where indicated- this document describes your financial responsibilities.

____ (initial) I understand that my vision plan covers "routine eye exams" however; if the doctor detects any medical condition, (dry eyes, floaters, etc.) the exam becomes a medical eye exam and will be submitted to my medical insurance company. If my insurance plan requires a referral, I will obtain one for the medical eye exam.

____ (initial) I understand that I am responsible to provide vision insurance for routine eye exams.

____ (initial) I understand exams for spectacles and contact lenses are separate exams. If you desire both exams on your visit, I may be charged a fee for a Contact lens fitting. Vision Institute will submit this charge to my insurance company or vision plan. If this charge is determined to be a non-covered service, I will be responsible for this charge.

I have read and I understand Vision Institutes financial policies and I am responsible for the payment of any fees associated with my care. Vision Institute reserves the right to change all fees at any time.

____

Patient Signature (or person authorized to sign for patient)

____

Date

Acknowledgement of Privacy Practices HIPAA

Patients Printed Name: ______________________________ Birthdate: ___/___/___

We would like to inform you of the rights you have as a patient under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

Under HIPAA, I understand that my personal information may be used to:

- Provide and coordinate my treatment among a number of healthcare providers who may be involved in my care directly or indirectly
- Obtain payment from third-party payers for my healthcare services
- Conduct normal healthcare operations such as quality assessment and improvement activities

I have been informed of Vision Institutes Notice of Privacy Practices and understand that I may request a copy of this notice for my own use. I understand that Vision Institute has the right to change the Notice of Privacy Practices and that I may contact the office to obtain a current copy of the Notice of Privacy Practices at any time. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I further understand that Vision Institute is not required to accept my requested restrictions, but if they are accepted then I understand that Vision Institute will honor my request unless it is an emergency situation.

Authorization to communicate protected health information:

In case of an Emergency who may we contact? ***(Know that this person will also have access to your health information)***

Name: ______________________ Relationship: __________________ Phone # :(   ) ________-__________

Who may we share your health information with?

Name/Relation: ________________________ their phone #: (   ) ________-__________

By signing below I acknowledge that I have been given, read, or offered a copy of Vision Institutes privacy policy and I understand that my information will be kept in my medical record and the instructions above and listed on the privacy policy will be honored until revoked by me in writing.

_______________________________________ ______/______/______

Printed Name **Date of Service**

____

Patient Signature **(or person authorized to sign for patient)**

Vision Institute

MEDICAL VS. VISION EXAM

Patients Printed Name: ______________________________Birthdate: _____/_____/______

Health insurance can be very confusing to understand. One important clarification is the difference between a Medical Eye Exam and a Vision Exam. Insurance coverage for eye exams varies depending on diagnosis and treatments.

YOU ONLY CHOOSE ONE OR THE OTHER IN ORDER TO BILL TODAYS EXAM

Vision Plans- *Sometimes routine vision coverage can be separate from your medical insurance or included in it.*

- These are routine or "Well Vision" exams and your eyes will be examined for any needed correction/refraction (glasses or contact lenses) and **not eye disease or symptoms of disease.**
- Vision exams require an authorization from your vision carrier, which we will request on the date of service. Most vision plans require a copay and/or a portion of the contact lens exam and/or optical materials be paid by you on the date of service.
- **If we find a medical eye problem during your exam, you will need to return on a different date of service under your medical coverage for treatment.**

I understand the above and would ***like you to bill my vision plan*** *for today's services. I understand that I may be subject to a copay, and/or a portion of the contact lens exam and/or optical materials be paid by me on the date of service.*

__________________________________/______________________________/________________

Sign Name **Print Name** **Date**

Medical Exams- *This is the same insurance you would use at your regular doctors or emergency room.*

- This is a medical examination for the diagnosis and treatment of diseases and conditions of the eye performed by a physician/surgeon.
  - This includes but is not limited to: cataracts, glaucoma, diabetic retinopathy, macular degeneration, dry eye disease, allergies, and many other potentially sight-threatening diseases.
- When we bill your medical insurance, you will most likely be subject to a copay, deductible, or co-insurance. This depends on your contractual agreement with your insurance company.
- NOTE: Most medical plans will not cover the refraction portion of the exam.

I understand the above and would ***like you to bill my medical insurance*** *for today's services. I understand that I may be subject to a copay, a portion of my yearly deductible, or a co-insurance amount.*

__________________________________/______________________________/______________

Sign Name **Print Name** **Date**