INSURANCE INFORMATION:

Primary Medical Insurance:_____

Secondary Medical Insurance (if applicable):_____

Vision Insurance:_____

**If you are not the primary policy holder, please enter that individual's information below:*

Policy Holder's Name:_____Relationship to Patient (circle one): Spouse, Parent, Other

DOB:_____SSN#:_____Address:_____

_____

City:_____State:_____Zip code:_____

Secondary Insurance (if applicable):

Policy Holder's Name:_____Relationship to Patient (circle one): Spouse, Parent, Other

DOB:_____SSN#:_____Address:_____

_____

City:_____State:_____Zip code:_____

INSURANCE COVERAGE

It is your responsibility to provide our office with accurate information for billing your insurance plan properly at the time of service. It is also your responsibility to know whether your visit with us is covered by your insurance plan fully, partially or not at all and whether your plan requires a referral from your primary physician before your visit. In the event you do not confirm this information and the insurer refuses full or partial payment, you will be held personally responsible for the cost of servies provided. **Initial_____**

ROUTINE VISION vs. MEDICAL INSURANCE COVERAGE

Vision insurance coverage is designed to cover routine eye service and to determine a glasses and/or contact lens prescription. When a medical condition or diagnosis is present, it may be necessary to file your examination to your medical insurance. Many times, we may not be aware of any medical diagnosis beforehand. Should this situation arise, we will do our best to inform you as to whether we will file your examination to your vision or medical insurance. In either case, the patient is responsible for any financial responsibility as dictated by their respective insurance company. **Initial_____**

COLLECTIONS FEE

You agree to reimburse us the collection fees of any collection agency, which shall be based on a percentage at a maximum rate of 33 1/3% of the amount due at the time your account is placed with a collection agency, and all costs and expenses incurred for any collection efforts on your account, including reasonable attorney's fees incurred by the collection agency. This shall cover all medical and vision treatment and services until revoked by either party in writing. **Initial_____**

SPECTACLE AND CONTACT LENS EXAMS

Exam for spectacles and contact lenses are separate exams. If you desire both exams on your visit, you will be charged an evaluation fee for a contact lens exam. We require this fee to be paid at time of service. **Initial_____**

REFRACTION FEE

A refraction is a test to obtain your best corrected vision, to determine the need for eye glasses, surgery and/or medicine. Most medical insurance plans, including Medicare, do not cover refractions. Our office

will collect the refraction fee along with any co-payment at the time of service. **Initial_____**

RELEASE OF INFORMATION

If you wish to allow another individual to speak to our office on your behalf concerning billing, prescriptions, records, and/or any other applicable medical issue, please enter that individual's name and information below. If no information is entered, we are legally obligated to refrain from releasing ANY information concerning patients over the age of 18 without verbal or written consent.

Name:_____Relationship:-_____

Name:_____Relationship:_____

My signature below verifies that I have reviewed a copy of the HIPAA Privacy Policy and agree to the Financial Policies listed above.

Signature of Responsible Party:_____Date:_____