PATIENT INFORMATION

Name ____ Date _____________ Cell Phone_______________________

Work Phone _____________________ Other Phone ________________________ **Email Address**___________________

Address____City______________ Zip________________

Social Security # ________-________-_________Birth Date_____________________________

Name of Insured (name on insurance card) ______________________ DOB of insured__________________

Insured Social Security #______________________ Insured Employer______________________

Vision Insurance_____________________________ ID#__________________________

Health Insurance_____________________________ ID#__________________________

What is the purpose of your visit today? Circle all that apply. LASIK, LATISSE, GLASSES, CONTACT LENSES, OTHER
If other please specify ____
Are you diabetic? Circle YES or NO
If so, we are legally responsible to bill your medical insurance vs your vision insurance for a routine eye exam.

Glasses are a made to order product, therefor, they cannot be returned for a refund. Glasses can be remade within a certain amount of time dictated by the lab. Contact manufacturers will not accept open or marked contact boxes for returns. All contact boxes must be unopened and unmarked in order to return for a refund. We apologize for any inconveniences!

Insurance Information, policies, and procedures

There are two types of Insurance that may contribute to services performed today. Vision Insurance (VSP, Eyemed, Davis Vision, ETC.), and Medical Insurance (BCBS, UHC, Cigna, ETC.). You may have one or both.

Vision Insurances cover routine wellness exams and hardware (contact lenses or glasses). They **do not** cover the diagnosis, treatment, or management of eye health problems.

A contact lens fit is considered elective and your Insurance will not cover that portion of the exam.

Medical Insurance can be used to help with management of medical eye care.

We will gladly bill one or both of your Insurances to help minimize your out of pocket expense.

If some fees are not paid by either insurance you will be billed for those appropriate fees, such as co-pays or deductibles as per your Insurance plan. I understand and accept that I am responsible for all charges not paid by my insurance plans.

We must have a copy of all Insurance cards in order for services to be billed

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT

I authorize treatment for the above named person and agree to pay all fees and charges for such treatment. I agree to pay all charges shown on statements promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. Charges shown on statements are agreed to be correct and reasonable unless protested within thirty days of billing date. Our staff will help with completion of insurance forms as an accommodation and convenience to you without charge. **IT IS THE PATIENT'S RESPONSIBILITY TO KNOW YOUR CONTRACT BENEFITS, ASSURE COLLECTION OF INSURANCE PAYMENTS TO US, AND TO NEGOTIATE WITH YOUR INSURANCE COMPANY OVER ANY DISPUTED CLAIMS**. It is agreed that payments will be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without assuming responsibility for the collection thereof. All account balances thirty days or older will be subject to a finance charge of 1.5% per month (annual rate of 18%). A charge of $25.00 will be assessed to all returned checks. Should collection become necessary, the responsible party agrees to pay a collection fee of up to 40% and all legal fees of collection, with or without suit, including attorney fees and court costs.

I have read and accept the above policies and Clinton Family Vision's Notice of Privacy practices has been made available to me.

Patient or Guardian Signature____ Date _____________________

Medical Information Release Form
(HIPAA Release Form)

Name:_________________________________ Date of Birth: _____/_____/_____

HIPAA Privacy Disclosure

Authorization to release information- I hereby authorize Clinton Family Vision to release any medical information that may be necessary for medical benefit or processing applications for financial benefit. This includes but is not limited to my Insurance Company, rehabilitation services, social security administration, and workers compensation.

Consent for treatment- I hereby authorize the practice to administer diagnostic and medical procedures as may be necessary for proper healthcare.

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

[ ] Spouse____

[ ] Child(ren)____

[ ] Other____

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing

Signed:______________________________ Date: _____/_____/_____

Witness:______________________________ Date: _____/_____/_____