PATIENT INFORMATION

For Billing purposes this form MUST be filled out COMPLETELY

Patient Name: (Last) _____ (First) _____ (MI)_____

Parent Name (if patient is a minor): _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Sex: M F ***Social Security #**: _____

Email:_____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Race: ☐ American Indian ☐ Asian ☐ Black or African American ☐ Pacific Islander ☐ White
☐ Other _____ ☐ Decline

EMPLOYER/SCHOOL INFORMATION

Employer/School: _____ Job Title/Grade: _____

EMERGENCY CONTACT

In case of a medical emergency please notify:

Name: _____ Contact Number: _____

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Guardian ☐ Other _____

HEALTH INSURANCE INFORMATION

Insurance Company Name: _____

Member ID/Policy #: _____ Group #: _____

Policy Holder Name: _____ Date of Birth: _____

Relation to Patient (if not self): _____

I hereby authorize InVision Eye Health to administer diagnostic and medical procedures as may be necessary for proper health care. I also authorize the release of any medical information necessary to process any bills to my insurance company and request payment of benefits to InVision Eye health. I acknowledge that I am financially responsible for any and all payments incurred not covered by my insurance. This authorization shall continue until such time as I revoke it in writing.

Signature: _____ Date: _____

CONTINUE ON BACK ➡

INVISION EYE HEALTH OFFICE POLICIES AND HIPAA PRIVACY

INSURANCE Our relationship is with you, not your insurance company. We will bill your insurance as a courtesy to you. It is your responsibility to verify that the provider you are seeing is participating on your plan. Due to the many different insurance policies and plans, our staff cannot guarantee your eligibility or coverage. Please be aware that insurance coverage does not guarantee payment and is subject to your plan's provisions. Be sure to check with your member benefits department about coverage before your appointment. All denials will be billed to you. It is your responsibility to advise our office of changes in your insurance.

PAYMENT It is your responsibility to pay any co-pay, deductible, or other balance not paid by your insurance. Payments and/or co-payments are due at the time of service. If your account is placed in collection status, any additional fees due to this will be added to your outstanding balance. This includes but is not limited to late fees, collection agency fees, attorney fees, court costs, interest, and other fines. It is your responsibility to pay these in full. In order for us to service our account or to collect any amounts you may owe, we may contact you by telephone, or by sending text messages or email. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. If you have any questions regarding an invoice you receive, please feel free to call our office, and we would be happy to review it with you.

DIVORCED PARENTS OF PATIENTS The adult who signs a minor child into our practice on the day of service accepts responsibility for all payments. This office will not send bills or records to the other parent/guardian for issues of payment. We will communicate about treatment and payment with the parent who signs the child in the day of service. Parents are responsible between themselves to communicate with each other about the treatment and payments.

CANCELATION/LATE POLICY We understand that life happens, and sometimes things happen outside of your control. We do still ask that you give at least 24 hours' notice before cancelling or rescheduling your appointment. Please also be aware that if you are more than 10 minutes late to your appointment, you may be asked to reschedule.

VISION PLANS VS MEDICAL PLANS InVision Eye Health provides both state-of-the-art vision care services and comprehensive medical eye care. Federal law strictly defines the differences between these types of care which determines whether a vision plan or medical plan is appropriate for the services you receive. Submitting billing to the appropriate insurance is primarily determined by the reason for your visit to our office and secondarily by the conditions or diagnoses you have. We follow a procedure called coordination of benefits to properly bill the correct insurance and minimize your out-of-pocket expenses.

A **"Comprehensive Vision and Eye Health Exam"**, as covered by a Vision Plan, is a routine healthy eye check-up and often results in the prescription of vision correction. Such exams are based on preventative care and include over 20 different tests to evaluate the condition of vision and eye health. Sometimes a vision exam results in the diagnosis of a medical condition, and any subsequent care or appropriate additional testing will be billed to medical insurance.

A **"Medical Office Visit"** involves treatment or recommendations other than vision correction. Common examples are conditions that cause red or dry eyes, eye pain, discharge, or loss of vision that cannot be treated with glasses or contacts. Discussion and education of such conditions during a routine vision exam is encouraged to take place. However, when this discussion results in a treatment change or medical prescription, it may be billed to medical insurance.

AUTHORIZATION TO RELEASE INFORMATION AND CONSENT FOR TREATMENT: I hereby authorize the InVision Eye Health to administer diagnostic and medical procedures as may be necessary for proper health care. I also authorize the release of any medical or incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration and Workers Compensation.

OFFICE POLICY ON PAYMENT: I acknowledge that I am responsible for payment on all charges. As a courtesy, my insurance will be billed for me. I understand it is my responsibility to pay any balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider.

HIPAA Privacy Policy: Our written Notice of Privacy Practices provides detailed information on how we may use and disclose protected health information. According to HIPAA provision, you have the right to receive and review a copy of this notice prior to signing this form.

- ☐ Yes, I want a copy of the office policies.
- ☐ Yes, I want a copy of the Notice of Privacy Practices

[*X*] *I have read and understand the above policies and agree to the terms and conditions stated. InVision Eye Health's Notice of Privacy Practices has been made available to me. This authorization shall continue until such time as I revoke it in writing.*

Patient Name: _____

Bill My Insurance: (Please Circle One) YES. If Yes, please provide SSN _____. NO. I will pay out of pocket.

Signature: _____ Relationship to Patient (if not self): _____ Date: _____