Welcome to Primary EyeCare

Patient Information:

Date:_____

Last Name_____First Name _____DOB:_____Gender: _____

Address:_____

City:_____ State:_____ Zip:_____

Day Phone:_____Cell Phone:_____Email:_____

How did you hear about us?: ____Current Patient ____Web/Facebook____Mailer____Referral_____from who?

Name of Insured/Policyholder_____ **DOB**:_____

Name of Insurance Carrier:_____

ID #: _____**Group #:**_____

Insurance Card Copied: _____Yes _____No _____No Card

ChampVA members/Need full social security # _____

Are you a member of VSP (Vision Service Plan) ____Yes ____No Last 4 #'s of policyholder's social security # _____

Financial Policy/Authorization and Release:

In order for my eyecare provider to service my account or to collect any amounts I may owe, I agree that I may be contacted at any number or address I have provided above or during a previous encounter. I understand that my eye exam and any optional contact lens fitting copayments are due today, and glasses or contact lenses may not be dispensed if those copayments are unpaid. I furthermore agree to pay any collection expenses incurred to collect any amount I may owe due to non-payment. I understand that I am solely responsible for the cost of all non-covered items, as outlined in detail on my receipt, which includes: the specific date of service, description of each procedure/service, and the amount I am responsible for paying out-of-pocket; I certify that I have been informed of all items and cost. I authorize the release of my information for my eyecare provider to file all insurance claims if we are a participating provider for your plan. However, there is no guarantee of benefit information and/or coverage, and if my insurance denies payment for any claims submitted, I will be responsible for full payment and can contact my insurance company directly should there be a dispute. My eyecare provider can also supply me with an itemized statement which I may submit to my insurance carrier should I need to submit for reimbursement. I understand that any follow-up appointments related to a contact lens evaluation are included for 6 months after the initial fitting, and should there be any follow-up appointments required after 6 months have passed, I am responsible to pay the professional service fee. Additionally, I know that any optional testing that I have verbally agreed to pay for is my responsibility to do as such on the date of service. Should I receive a medical examination, I understand that my major medical insurance will be billed, and I will be responsible for any deductibles, coinsurance, or copayments that may be due.

I have read and understand the statement of financial responsibility.

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and /or other health practitioners.

I authorized the release of any information including the diagnosis and the records of any treatment or examinations rendered to me or my minor child to:_____

_____ _____

Signature of Patient or Parent (if mInor) Date

HIPAA Privacy Practice Acknowledgment

I have received or was offered and declined a notice of privacy practices

.Signature:_____ Date:_____