Eye Care Associates

Patient Information

Name: _____ SSN#: _____-_____-_____
(Last) (First) (M.I.)

Address: _____ _____
(Street) (Apt. #) (City) (State) (Zip)

Phone: _____ _____ _____ Email: _____
(Home) (Cell) (Work)

DOB: _____/_____/_____ Sex: Male / Female Preferred Language: _____

Race: Asian African-American Caucasian (White) Native-American Other_____ Decline

Preferred Pharmacy: _____ Ethnicity: Hispanic/Latino Non-Hispanic/Latino

Preferred Communication: Email Postal Telephone May we text appointment reminders to your cell phone? Yes/No

Employer Information

Employer Name: _____ Phone: _____

Address: _____ _____
(Street) (Ste. #) (City) (State) (Zip)

Insurance Information

Insurance Company: _____

Insured's Name: _____ _____ _____-_____-_____
(Last) (First) (M.I.) (DOB) (SSN#)

Address: _____ _____
(Street) (Apt. #) (City) (State) (Zip)

Patient's Relationship to Insured: Self Child Spouse Other _____

Policy # / Member ID: _____ Group #: _____

Responsible Party Information *(if patient is under age 18, parent or guardian completing registration sheet)*

Name: _____ SSN#: _____-_____-_____
(Last) (First) (M.I.)

Address: _____ _____
(Street) (Apt. #) (City) (State) (Zip)

DOB: _____ Phone #: _____ Relationship: Parent Guardian

Financial Agreement

I acknowledge that payment is due at time of treatment, unless other arrangements have been made. I accept the financial responsibility for all charges not covered by my insurance company. Past due accounts will be referred to a collection agency and credit bureau.

_____ _____
Patient or Legal Guardian Date

Authorization for Treatment

I hereby authorize and request examination and/or medical treatment by the physicians and the staff of Eye Care Associates. I further authorize any procedure that the judgement of the above-named physicians and staff may deem necessary during any treatment. I also authorize the administration of any anesthetics and analgesics, which above physicians and staff deem advisable.

_____ _____
Patient or Legal Guardian Date

Medicare Assignment & Supplement

I authorize Eye Care Associates to release to Centers of Medicare and Medicaid Services information about me needed to determine benefits payable for related services. I request that payment of authorized Medicare and Medicaid by made to Eye Care Associates for services furnished to me by their physicians. I realize that this is a lifetime authorization.

_____ _____
Patient or Legal Guardian Date

Insurance Assignment

I request that payment of insurance benefits be made to Eye Care Associates for services furnished to me by their physicians. I realize this is a lifetime authorization. I also authorize release of any medical information to my insurance company listed above.

_____ _____
Patient or Legal Guardian Date

Consent to Send or Receive Medical Records

Eye Care Associates has my consent to use and disclose my health information for the following purposes: to provide medical service and treatment alternatives, to collect payment for services rendered, for healthcare operations, to contact you with appointment reminders, and to inform you of health-related products and services.

_____ _____
Patient or Legal Guardian Date

Picture Consent

I authorize Eye Care Associates to obtain a photo of myself to be kept in my medical records for the purpose of identification and medical documentation.

_____ _____
Patient or Legal Guardian Date

Notice of Privacy Practices for Protected Health Information

Eye Care Associates has provided me with a copy of its Notice of Privacy Practices for Protected Health Information. I understand that this Notice describes how my medical information will be protected. I understand that the Health Insurance Portability and Accountability Ace of 1996 (HIPPA) requires Eye Care Associates to protect my information. I understand how Eye Care Associates may use and disclose my health information.

I hereby acknowledge receipt of the Notice of Privacy Practices, version effective date of 06/25/2019:

Patient Name: _____ Date: _____

Signature of Patient: _____

If patient is under 18 or is legally incapable of making their own legal and medical decisions:

Signature of Legal Guardian/Representative: _____

Patient Health/Patient Account Information Permission

According to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), our clinic is not authorized to discuss your medical information or patient account information with anyone but the patient, nor will we release prescription materials to anyone but the patient. Sometimes, this is not always convenient or possible for our patients; therefore, by completing the below listed information, you are granting Eye Care Associates permission to release your medical information, patient information, and/or prescription materials to individuals that you list below.

Date: _____/_____/_____

I, _____, give the staff of Eye Care Associates permission to discuss my patient chart/medical information with, or release my prescription materials to, the following listed persons:

Circle Access Type

Name: _____ Relationship: _____ All Access/Pickup Only

Name: _____ Relationship: _____ All Access/Pickup Only

Name: _____ Relationship: _____ All Access/Pickup Only

Name: _____ Relationship: _____ All Access/Pickup Only

Eye Care Associates

Eye Glasses Release Form

By signing below, you are acknowledging that you have given permission to Eye Care Associates to make and bill for eye glasses that you have chosen. You also acknowledge that even if you do not come pick your glasses up, you are still responsible for the payment of the glasses. The process to make eye glasses is costly and time intensive. Each pair of glasses is made specifically for your prescription and cannot be re-used.

_____

Patient Name

_____ _____

Patient/Guarantor Signature Date

_____

Phone Number

_____ _____

Witness Signature Date

Contact Lens Policy

Professional Standards of Care recommend that all people who wear contact lenses have a full comprehensive examination and contact lens evaluation at least once every year. This form is intended to make clear any misconceptions concerning the professional services and material costs of contact lenses. Your vision benefits may not cover, or only cover a portion, of the charges for a contact lens evaluation. **Please read carefully and sign at the bottom.**

- We WILL NOT dispense contact lenses or write a contact lens prescription without a comprehensive exam and contact lens evaluation, including all necessary progress checks. This must be done every year.
- A comprehensive exam consists of tests which include:
    - Determination of refractive status of your eyes (myopia, hyperopia, astigmatism, presbyopia).
    - Evaluation of ocular tissues internal and external and diagnosis of diseases/disorders relating to the eye.
- A contact lens evaluation must be done in addition to the comprehensive exam, even if you do not have a change in your contact lens prescription. A contact lens evaluation fee is an additional professional fee. It is a separate fee and IS NOT included in the comprehensive exam fee. This fee varies and is dependent on the level of complexity of the fitting process.
- The tests for contact lens wearers include:
    - Measurement of the curvature of the cornea to determine the proper parameters of a contact lens which will best fit each eye, and for previous wearers, to assure that your current contact lenses are still the proper fit.
    - Evaluation of the performance of both the current and/or new contacts lenses on each eye (visual acuity, coverage, centration, movement, tear exchange, cleanliness, etc.).
    - Assessment of the ocular tissues involved in contact lens wear and determination if these tissues are responding favorably to contact lens wear.
    - Choosing the correct lens material and design for your individual needs.
    - Ongoing progress checks as needed up to 3 months (90 days). Any additional progress checks outside the initial period will be charged at $40 per visit.
    - If trial contacts are available at your fitting, they are included and there is no additional charge. These trials allow you to try out the contacts for a short time before you purchase a normal supply.
        - After the 1st pair of trials are given (per power), a dispensing fee of $20.00 will apply for providing additional pairs of trial lenses.
        - Other than the initial pair of contacts, the patient is responsible for ordering and purchasing a supply of contacts. Contacts must be paid for prior to Eye Care Associates ordering them for you since they are specific for your prescription.

Vision Benefits

If you have vision benefits, your exam co-pay is only for the comprehensive portion of the exam. Contact lenses are considered an elective form of vision correction; therefore, the contact lens evaluation is not covered by the comprehensive exam coverage under your vision benefits. Unless your vision carrier provides some reimbursement toward your contact lens evaluation and/or contact lenses, you are responsible for the full amount of the contact lens evaluation fee on the date of service.

I have read and by signing, I understand that if I choose to be fit with contact lenses, I am financially responsible for all fees not covered by my vision benefits.

_____	_____	_____
Print Name	Signature	Date