Welcome to Essential Vision Care

Patient Name: ____ Birth Date: ___________________ Sex: [ ] M [ ] F

Address: ____ Phone: _____________________ (cell, home, work)

Email Address: ______________________________________ Previous Eye Doctor: _________________ Last Exam: __________

Social Security Number ___________________ Who may we thank for referring you? ___________________________________

Health Review of Systems (YOURSELF) please circle any of the following conditions you may have: Check here if **NONE** ☐

Constitution: Cancer….Developmental Disabilities….Fatigue Syndrome

Ears/Nose/Throat/Mouth: Dry Mouth….Laryngitis….Hearing Loss….Sinusitis

Neurological: Stroke/CVA….Migraine….Cerebral Palsy….Tumor….Multiple Sclerosis….Epilepsy

Psychiatric: Bipolar….Attention Deficit….Anxiety Disorder….Depression

Cardiovascular: Stroke/CVA….High Blood Pressure….Congestive Heart Failure….Vascular Disease….Heart Disease

Respiratory: Bronchitis….Asthma….Chronic Obstruction….Emphysema….Sleep Apnea

Gastrointestinal: Crohn's….Colitis….Ulcer….Acid Reflux….Celiac Disease

Genitourinary: Chlamydia….STD….Prostate Disease/Cancer….Kidney Disease….Herpes….Pregnant…. Nursing

Musculoskeletal: Gout….Arthritis….Fibromyalgia….Muscular Dystrophy….Ankylosing Spondylitis….Osteoporosis

Integumentary: Eczema….Rosacea….Herpes Zoster/Shingles….Psoriasis….Herpes Simplex/Cold Sores

Endocrine: Hormonal Dysfunction….Thyroid Dysfunction….Type I Diabetes….Type 2 Diabetes

Hematologic/Lymphatic: Anemia….High Cholesterol….Ulcer….Large-Volume Blood Loss

Allergy/Immunologic: Drug Allergies….Rheumatoid Arthritis….Environmental Allergies….Sjogren's Syndrome….Lupus

Eyes: Cataract….Glaucoma….Amblyopia (Lazy Eye)….Strabismus (Eye Turn)….Macular Degeneration

Other Eye/Medical Condition:____

Name of Regular Physician(s):____

About Your Insurance: Some medical and all vision insurance plans cover eye care services and materials. You may have one or both policies, and the office may accept both. Vision insurance plans only cover "**routine vision exams**" along with eyeglasses or contact lenses. They DO NOT cover exams that are for diagnosis, management, or treatment of eye diseases. Medical insurance plans must be used if you have any eye health problems or systemic health problems that have ocular complications, for example, diabetes mellitus. The doctor will determine if these conditions apply to you at each visit, but some are determined by your case history. If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits, if applicable, to minimize your out-of-pocket expenses.

I have read and agree with this policy:

Signature X ____ Date _____________

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have reviewed a copy of Rebecca J. W. Brown, OD's Notice of Privacy Practice. I may have a copy at my request.

____ _________________

Signature (Parent or Guardian if under age 18) **Date**

*********PLEASE PROVIDE OUR OFFICE WITH A MEDICTION LIST IF AVAILABLE*********

Essential Vision Care Payment Policy, Assignment, and Release Form

Thank you for choosing us as your primary eye care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this office policy form. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request…

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your medical and vision insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 15 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular or certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. If you are more than 15 minutes late for your scheduled appointment, you will be considered a no show and asked to reschedule. Please help us to serve you better by keeping your regularly scheduled appointment.

9. Payments. A 50% deposit is due before any spectacle materials are ordered and the balance is due upon delivery. All contact lens fees must be paid at the time of service/ordering. Since eyeglasses are a custom prescription item, there are no refunds for eyewear canceled after the lab work has started.

10. Assignment and Release. By signing below you authorize payment of benefits for services and/or materials per assignment and assume responsibility for all charges. You authorize the release of any information necessary to process any claims. You authorize the use of this signature on all insurance submissions and other documents.
Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy, assignment, and release and agree to abide by its guidelines:

____ ________________

Signature (Parent or Guardian if under age 18) **Date**