ABOUT YOUR INSURANCE

There are two types of insurance that help to pay a portion of your eye care services and products: Vision Care Plans and Major Medical Insurance.

-Vision care plans only pay toward routine refractive vision exams. They may also consider payment for glasses and/or contact lenses. These sorts of plans are in addition to your major medical insurance and typically do not consider payment for diagnosis, management, and treatment of eye disease.

-Major medical insurance will be billed if you have any eye or systemic health issue that has ocular complications. Your optometrist will determine if these conditions apply to you.

-If you have both types of insurance (Major Medical and Vision), it may be necessary to bill some services to your vision plan, and others to your medical insurance. We will use coordination of benefits to help minimize patient out-of-pocket expense.

-We will bill your insurance plan(s) for services if we are participating providers. We will obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not payable by your insurance, we will bill you for any unpaid deductibles, co-pays, or non-covered services as allowed by the insurance contract.

AUTHORIZATION TO SUBMIT CHARGES

I request that payment of benefits from my insurance company be made to Portsmouth Vision Center for any services provided. I hereby authorize the release of any medical information necessary to process these claims. In Medicare-assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered services. This may include the refraction, which is a measurement of the lens power necessary to prescribe glasses or other corrective lenses—this is a $27.00 fee if not paid by your insurance carrier.

FINANCIAL RESPONSIBILITY

As a courtesy to our patients, we will submit charges for services to your insurance carrier if applicable. Any balance not paid by your insurance carrier is your responsibility and you may receive a statement for unpaid amounts such as deductibles, co-pays, and/or non-covered services.

Our office policy is to pay all estimated co-pays at time of service and in full to order materials.

I understand that if this account is not paid within 90 days from receipt of first statement, the amount will have finance charges added, and may be considered for placement with our outside collection agency. Any additional fees for delinquent accounts, as determined by Portsmouth Vision Center, will be my responsibility.

CONTACT LENS PATIENTS

Please be aware that the fitting or evaluation of contact lenses is performed in addition to your annual eye exam and there is a separate fee for this service. The fee is based on the type of contact lenses prescribed and the complexity of the evaluation or fitting process. This service may not be covered by insurance.

CONSENT TO TEST

I hereby grant the optometrists of Portsmouth Vision Center to complete all testing, whether screening or diagnostic, that he or she recommends. I understand that these services may not be covered under my insurance plan due to co-pays, deductibles, or non-covered amounts.

SIGNATURE FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I acknowledge that I have received a copy of the privacy practices of this office, detailing how my health information may be used and disclosed as permitted under the federal and state law. The effective date is 09/23/2013. I understand that my signature only represents my receipt of this notice.

PATIENT INFORMATION FORM DATE:

TITLE (CIRCLE ONE): MR. / MRS. / MISS / MS. / DR. / FATHER SEX: MALE / FEMALE

NAME: _____ _____ _____
FIRST NAME MIDDLE INITIAL LAST NAME (WITH SUFFIX IF APPLICABLE)

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ DAYTIME PHONE: _____

CELL PHONE: _____ EMAIL: _____

PREFERRED METHOD OF CONTACT: PHONE CALL TEXT EMAIL

MARITAL STATUS: SINGLE MARRIED DIVORCED LEGALLY SEPARATED WIDOWED
(PLEASE CIRCLE ONE)

EMPLOYMENT STATUS: EMPLOYED FULL-TIME EMPLOYED PART-TIME NOT EMPLOYED RETIRED
(PLEASE CIRCLE ONE)

SELF-EMPLOYED FULL-TIME STUDENT PART-TIME STUDENT NOT A STUDENT DISABLED

EMPLOYER: _____ OCCUPATION: _____

PRIMARY/ SECONDARY (IF APPLICABLE) MEDICAL INSURANCE: _____/_____

PRIMARY/ SECONDARY (IF APPLICABLE) VISION PLAN: _____/_____

POLICYHOLDER NAME: _____/ _____

POLICY HOLDER DATE OF BIRTH: _____/ _____

POLICY HOLDER SOCIAL SECURITY NUMBER: _____/ _____

PERSON RESPONSIBLE FOR ACCOUNT: (CIRCLE ONE) SELF / SPOUSE / PARENT / GUARDIAN

IF NOT SELF, INFORMATION ABOUT RESPONSIBLE PARTY:

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

I, the undersigned, attest that the information listed above is complete and true to the best of my knowledge. I have read and understand the office and financial policies of Portsmouth Vision Center listed on the back side of this form.

_____ _____

Patient Signature (OR parent/guardian if under 18) **Date**