EYE CARE CENTER

WELCOME TO OUR OFFICE!

DATE_____

Thank you for choosing our practice for your eyecare needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.We need to update our records yearly, so if the information has changed since you were here, please fill out a new form.

PATIENT INFORMATION

Name _____
LAST FIRST MI NAME YOU WISH TO BE CALLED

Address_____ City_____ State_____ Zip_____

Date of Birth_____ Social Security Number _____

Are you: ☐ Minor ☐ Married ☐ Divorced ☐ Widowed ☐ Single TITLE: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Rev.

Home phone_____ Work phone_____ Prefer to receive calls ☐ Work ☐ Home ☐ Either

Your or your parent's employer _____ Occupation_____

Business Address_____City_____ State_____ Zip_____

Spouse's or parent's name _____Business_____ Work phone_____

Person to contact in case of emergency_____ Phone_____

RESPONSIBLE PARTY

Name of person responsible for this account?_____ Relationship to patient_____

Address _____ City_____ State_____ Zip_____

Name of employer_____Work phone_____

HOW DID YOU HEAR ABOUT OUR OFFICE?

(Please check all that apply)

☐ Friend or relative: Name _____

If not a patient, their address _____

_____

☐ Another health care practitioner: Who _____

☐ Yellow Pages: Which directory _____

☐ Radio: Which station _____

☐ Previous patient: Name_____

☐ Location _____

☐ Internet: Which website_____

☐ Participating eye care plan/Insurance_____

☐ Other _____

DIAGNOSTIC ISSUES

(Please check all that apply)

Please list any concerns about wearing *glasses* or *contact lenses*:

_____

_____

_____

☐ Do you have more than one pair of current Rx glasses?

☐ Do you work on a computer for long periods of time?

☐ If you wear glasses, would you benefit from thinner, lighter lenses?

☐ Do you spend a lot of time outdoors?

☐ If you wear bifocals, do restricted windows, lines, or head tilting bother you?

☐ Are there times you'd rather not wear glasses?

☐ Are you interested in a "test drive" of the latest in contact lens designs?

☐ Laser vision correction is a common choice to reduce or eliminate the need for glasses or contacts. Do you desire information regarding laser corrections?

RECALL AUTHORIZATION

I understand that your office uses a post card system for notification of examination due date.

Please notify me by post card ☐ Yes ☐ No. I prefer to be notified by telephone ☐ Yes ☐ No. My initials_____

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM

INSURANCE INFORMATION

Name of insured_____ Relationship to patient_____

☐ Cigna ☐ State Health Plan ☐ BCBS ☐ Medicare ☐ Medicaid ☐ United HealthCare ☐ VSP

☐ Carolina Care Plan ☐ Spectera ☐ Eyemed ☐ Other_____

Group No._____ Policy No._____

Regarding Insurance
While it is our pleasure to complete any insurance forms, we do not accept assignment of benefits without prior authorization. We cannot bill your insurance company unless you give us your current insurance information. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. If your insurance company has not responded with payment after 45 days from the date of service, you may receive a bill for payment due. It is your responsibility to provide your insurance company with correct information at all times and to be aware of your policy's benefits. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

Medicare Participants
I request that payment of authorized Medicare benefits be made on my behalf to Branch & Stafford Optometric Associates, P.A. for services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.

Branch & Stafford Optometric Associates, P.A. accepts 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. Coinsurance and the deductible are based upon the charge determination of the Medicare Carrier.

Other Participants
I hereby authorize payment of my medical and surgical benefits to Branch & Stafford Optometric Associates, P.A. I understand I am financially responsible for any charges whether or not paid by said insurance. If my insurance company or health plan designates co-payments and/or deductibles, I agree to pay them to Branch & Stafford Optometric Associates, P.A. I authorize Branch & Stafford Optometric Associates, P.A. to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

OUR FINANCIAL POLICY

Thank you for choosing us as your vision care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. All patients must complete our insurance and personal information forms before seeing the doctor.

Payment for professional services is due upon completion of the examination.
Complete payment is due when any materials are received.

We have two methods of payment available for services and materials.
Please check one: ☐ Cash / Check at each visit ☐ Credit Card: ☐ MC ☐ VISA ☐ American Express

There is a $5 service charge on all billings. Any balance over 30 days is subject to a 2% monthly finance charge. Accounts requiring collection assistance are subject to an additional 68% in collection agency fees. There is a $30 service charge on all returned checks.

AUTHORIZATION

I certify that I have read and understand that all information and questions have been answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I hereby consent for the use or disclosure of my individually identifiable health information to carry out treatment, payment, or health-care operations. This includes assignment of benefits from insurance companies. This consent is authorized for the following health-care providers: Dr. Robert W. Branch, O.D., Dr. Timothy A. Stafford, O.D., and Dr. Paul W. Derrick, O.D. I understand that I have the right to request that this provider restrict how protected health information is used or disclosed to carry out treatment, payment or health-care operations. I have the right to revoke the consent in writing except to the extent that the provider has taken action prior to the revocation. I understand that this authorization is voluntary. I understand that I am responsible for any costs in excess of the benefits payable by my insurance plan.

Signature of Patient_____ Date_____
(or patient's representative)