The Eye & Laser Center

PATIENT INFORMATION

PLEASE PRINT INFORMATION				
PATIENT'S NAME		S.S. #	DATE OF BIRTH	☐ MALE ☐ FEMALE
MAILING ADDRESS		CITY, STATE & ZIP	HOME EMAIL ADDRESS	
HOME PHONE	CELL PHONE	PREFERRED PHONE (circle one) CELL HOME	MAY A DETAILED MESSAGE BE LEFT ON YOUR PREFERRED PHONE? (circle one) YES NO	
EMPLOYER NAME AND ADDRESS		WORK PHONE	MARITAL STATUS *(circle one)* S M W D	
RESPONSIBLE PARTY IF OTHER THAN SELF		RELATIONSHIP TO RESPONSIBLE		
EMERGENCY CONTACT/ RELATIONSHIP		EMERGENCY CONTACT NUMBERS		
FAMILY PHYSICIAN NAME, ADDRESS, PHONE NUMBER				
NAME OF REFERRING PHYSICIAN OR OPTOMETRIST		ADDRESS OF REFERRING PROVIDER		
NAME OF PREFERRED PHARMACY		ADDRESS OF PREFERRED PHARMACY		

ACKNOWLEDGEMENT, AUTHORIZATION, AND CONSENT

Authorization for Examination and Treatment:
I hereby authorize the examination and/or treatment considered necessary for me and the treatment and procedures will be performed by the providers of Lancaster Eye Clinic, PA DBA, The Eye and Laser Center. I understand that no guarantee or assurance has been made as to the results that may be obtained.

Assignment of Benefits:
I hereby assign and authorize my insurance carrier or other benefits plan including Medicare, other government sponsored insurances and benefits of which I may be covered and/or all commercial payors to make payments on my behalf directly to Lancaster Eye Clinic, PA DBA The Eye and Laser Center. I authorize Lancaster Eye Clinic, PA to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. I also assign any Medigap benefits to be paid directly to my provider. If my insurance or benefits plan will not direct payment to Lancaster Eye Clinic, PA, I agree to forward to Lancaster Eye Clinic, PA all benefit payments which I receive for the services rendered by Lancaster Eye Clinic, PA and its health care providers. I permit a copy of this authorization to be used in place of the original.

Financial Responsibility:
I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE. I understand that all charges for services rendered at Lancaster Eye Clinic, PA are ultimately the responsibility of the patient. Lancaster Eye Clinic, PA will file claims with most insurance and benefit plans, however, once the claim has been processed, all co-insurance, copay, and deductible amounts as well as fees for any service rendered not covered by my insurance policy are due upon receipt of the billing statement. You will receive a statement from The Eye and Laser Center for such fees not collected at the time of service. I further agree that, if permissible by law, I will reimburse Lancaster Eye Clinic, PA for all costs, expenses and attorney's fees that may be incurred in attempts to collect those charges.

Authorization to Release Information:
I hereby authorize the release of any medical or other information necessary to process claims on my behalf. I agree to be fully responsible for all lawful debts incurred by myself or child/children for services. I also authorize any holder of medical information about me to be released to the Health Care Financing Administration upon their request.

I certify that I have read and understand the above statements, that all of my questions have been answered to my satisfaction, and that I agree with each statement above.

_____ _____ _____

Patient/Person Legally Responsible ***Relationship to Patient*** ***Date***

PLEASE COMPLETE BOTH SIDES

COMMUNICATION AND PRIVACY ACKNOWLEDGEMENT

PATIENT NAME	DATE

FAMILY & FRIENDS:

It is the policy of The Eye and Laser Center not to release confidential medical information regarding your treatment to family members or friends except for parent/legal guardian, other persons authorized by the patient, as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment, in emergency situations, or as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you need or want your medical information to be provided to family members, friends, or caretakers, please indicate that below. By signing below, you authorize the following people to receive information regarding your treatment or care: (If you wish to add names later on, please confirm this in writing).

ALTERNATIVE COMMUNICATIONS

The policy of The Eye and Laser Center is to communicate with you through the following means: Mail, to the listed home address; telephone through your preferred listed phone (text messages for appointment reminders if a cell phone is listed); and secure email if an email address is listed. You may request other reasonable alternate communication means. Please request alternative communication means in the appropriate section below.

NAME / RELATIONSHIP	PHONE NUMBER
NAME / RELATIONSHIP	PHONE NUMBER

ALTERNATIVE COMMUNICATION REQUESTED (circle one)	COMMUNICATION METHOD REQUESTED
YES ***NO***	

Patient Name (Printed)

Patient/Guardian Signature | Relationship if other than patient | Date

PHARMACY INFORMATION RELEASE

In order to provide high quality and more efficient care, The Eye and Laser Center can obtain your medication information from your pharmacy. This information can be critical to providing safe and effective care. By signing below you authorize the release of your medication records from your pharmacy.

Patient Name (Printed)

Patient/Guardian Signature | Relationship if other than patient | Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

The above authorizations are voluntary and I may refuse to agree to their terms without affecting any of my rights to receive healthcare at the Practice. These Authorizations may be revoked at any time by notifying the Practice in writing at the Practices mailing address marked to the attention of "HIPAA Compliance Officer." The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation. I may see and copy the information described in this form and if I request, a copy of this form after I sign it. I acknowledge that all of my questions were answered to my satisfaction and that I fully understand this authorization form. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked. I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out: • Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment); • Obtaining payment from third party payers (e.g. my insurance company); • The day-to-day healthcare operations of your practice such as quality assessments.
I have also been informed of and given the right to review and a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA

Patient Name (Printed)

Patient/Guardian Signature | Relationship if other than patient | Date

Thank you for choosing us as your healthcare provider. We are committed to providing you the highest possible quality care. We also strive to keep our fees as reasonable as possible. In order to accomplish high quality care at a reasonable cost to our patients, we must require all patients to pay their co-pays, deductibles, and non-covered services at the time of service. Thank you for understanding.

If you are unable to pay at the time of the visit, we will gladly reschedule your appointment. We accept cash, checks, Visa or MasterCard. Debit cards are also welcome.

INSURED PATIENTS

It is your responsibility to provide the receptionist with all current vision **and** health insurance information. If we have a contract with your insurance company, we will gladly file your claim and act as your advocate in an effort to get the claim paid. You, however, are ultimately responsible for all charges. If we have not received payment from your insurance company within 60 days from the date of service, you will become responsible for payment.

You are also responsible for knowing whether a referral or prior authorization is needed from your primary care physician. You must obtain this referral/authorization **prior** to your appointment. If a referral is not obtained, you will be expected to pay the full amount at the time of service or to reschedule your appointment.

Your insurance company reserves the right to reprocess and adjust previously paid claims for up to four years following the actual date of service. If your insurance company reprocesses any of your claims and reclaims monies previously paid to us, you will become responsible for payment. We, however, will gladly work as your advocate to assist you in recouping the reclaimed payment.

ROUTINE VISION COVERAGE

Your vision coverage/insurance is intended to provide you with a baseline eye evaluation to **update your glasses prescriptions only.** If the doctor discovers a medical eye problem during a routine exam, the doctor will inform you that your visit is now a medical exam and will be billed to your medical health insurance. You may choose to finish the routine examination and return at a later date for the medical exam.

UNINSURED PATIENTS

If you do not have insurance, payment is required in full at the time of service unless arrangements have been made in advance with one of our financial counselors.

CO-PAYS AND DEDUCTIBLES

Prior to your appointment, we will contact your insurance company to verify benefits. Your insurance company will advise us how much to collect from you at the time of your visit. **In order to comply with the contract we have with your insurance company, we must collect any co-pay and deductible amount at the front desk before any services are rendered.**

REFRACTIONS

The refraction is the portion of the eye exam which determines whether your vision can be improved with glasses or contact lenses. The refraction is not only necessary to determine your eyeglass or contact lens prescription, it is often the first step in determining whether you have a medical condition affecting your vision. **Few insurance plans pay for refractions.** The charge for refraction is $50. **Because the prescription for eyeglass lenses and/or contact lenses is included in the refraction, we require that you pay your refraction fee before we release your lens(es) prescription.**

SURGICAL PROCEDURES AND FEES

There are several steps involved in preparing for your surgery, so it is important that you keep the scheduled surgery date in order to complete your planned treatment. It is your responsibility to contact our office as soon as possible if there is a change in your contact information. It is important that we be able to contact you with any questions or changes regarding your surgery. If we are unable to contact you in a timely manner, your surgery may be cancelled.

(Over)

It is also your responsibility to advise us if there is a change in your insurance. We will verify insurance benefits prior to the date of surgery. A deposit is required on the estimated patient-responsible portion of the surgical fee prior to medically-necessary procedures. Payment in full is required prior to elective procedures. **A cash discount is offered to patients who pay by cash or check.**

OPTICAL ORDERS

Because your eyeglass prescription and lens measurements are unique to you, any lens or eyeglass order must be treated as a special order – which means once the order is placed we cannot cancel it or return the lens(es) or eyeglasses after they are made. We, therefore, require a **non-refundable** deposit before the order can be placed. If you have insurance coverage to help pay for your order, we will collect payment for any non-covered options and/or any overages for which your insurance will not pay before your order is placed. If you do not have insurance coverage to help pay for your order, we will collect a 50% deposit before your order is placed and the balance before your new eyewear is delivered.

If, for any reason, you are dissatisfied with your new eyewear, we will gladly exchange for equal value or refund all but the non-refundable deposit (50%) within **30 days** of initial delivery of your eyewear.

CONTACT LENSES

Contact lens services (original fitting and annual evaluations) are in addition to eye exams. Because contact lens wear is almost always elective, we require that you pay for any contact lenses in full before delivery. Additionally, if you have an outstanding balance with our office, you will be required to pay that balance in full before we will dispense contact lenses to you.

If your contact lens prescription and measurements are unique to you, we cannot cancel the order once it is made, nor can we return the lenses once they are made for you. You, therefore, are responsible for payment of the lenses upon order.

MISSED APPOINTMENTS

When you miss an appointment, you deny valuable time to another patient in need of medical care. We, however, realize unexpected circumstances may arise. When possible, please call 24 hours in advance to cancel/reschedule your appointment. It is our policy to waive the fee for the first missed appointment. A **$20 fee**, however, will be charged following the second missed appointment.

STATEMENTS

In order to be cost-effective, we do not send statements to patients with balances less than $15. Instead, we collect these small balances at future visits.

COLLECTION ACCOUNTS AND RETURNED CHECKS

Any balance not paid within **60** days may be turned over to our debt collection agency and assessed a $30 processing fee. Returned checks will be subject to a **$30** processing fee. The amount of the returned check plus the $30 processing fee must be paid by cash, money order or credit card within **10 days** of receipt of written notifi cation from our office.

MINOR PATIENTS

If the patient is a minor (anyone younger than 18), a parent or guardian must be present. Please be sure the adult bringing the minor is prepared to render any payment necessary. If a parent or guardian cannot be present at the time of the visit or if the adult accompanying the minor is not prepared to pay for the visit, we will gladly reschedule the visit to another day.

Thank you again for choosing our office. If you have any questions concerning the above financial policy, please ask to speak to one of our financial counselors.

I HAVE READ AND AGREE TO THIS FINANCIAL POLICY. I UNDERSTAND AND TAKE RESPONSIBILITY FOR INSURANCE AND PAYMENTS AS STATED ABOVE.

Patient Name (please print)	Responsible Party Signature	Date