

Family Vision Care

Dr. Tim Sellers

# Patient Information to be filled out once per year

**Last Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**First Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**MI**\_\_\_\_

**Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 mailing address city state zip code

*If mailing address is P.O. Box, what is your physical address?*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 address city state zip code

**Email Address** *(BEVC internal usage only)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home ph**(\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Cell**(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Work**(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**ext\_\_\_\_\_\_\_\_\_**

**Employer**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Contact**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital status:** **Single Married Other Sex: Male Female**

**Date of Birth** \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ **Social Security Number** \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

**Insurance Coverage Information** (*Please present your insurance card(s) and picture ID to the front desk*)

Medical Insurance \_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (if self, please put “self)

Insured Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary / Vision Insurance \_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (if self, please put “self)

Insured Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### How did you hear about us?

*HIPAA: I authorize the release of my medical and billing information to the following:*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient Date of Birth

* Family\ Friends
* Internet
* Insurance Listing
* Doctor\ Referral
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*I have read and understand the financial policy (on back).

\*I hereby authorize payment of medical benefits for all covered

services to be paid directly to Family Vision Care.

\*I accept financial responsibility for any service(s) provided for

me not covered by my insurance policy and understand that

these services are due the day they are rendered. If our

office does not participate with your insurance plan, I also accept responsibility for any and all fees.

\*I understand that all previous outstanding balances will be due when I check in for my appointment.

\*All other out of pocket amounts such as co-pays, coinsurance or deductibles will be due before I leave on my date of service or after insurance processing, within 30 days of billing.

\*This practice accepts cash, checks, money orders, Care Credit, VISA, and MC, and Discover.

**Privacy Release: I have been given notice of the Privacy Policy of Family Vision Care.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature (***If patient is a minor, parent signature is required***) Date



Family Vision Care

Dr. Tim Sellers

**Patient Acknowledgements**

***Dilation***

We recommend dilation eye drops for all patients **every year**. A dilated examination allows your Optometrist to see the entire inside of your eye. Most people experience a few side effects such as *mild blurring of vision, sensitivity to bright light and you may not be able to do any close work such as reading or sewing for a few hours after the exam*. **Dilation is a very safe procedure and you should experience little inconvenience or discomfort.** If dilation is done the day of service, it is COVERED by your insurance policy OR included in the pricing of the exam at NO additional charge.

I give permission to have the above test performed \_\_\_\_\_\_ YES \_\_\_\_\_\_ NO (I understand my doctor will be limited to make certain diagnosis)

***Glaucoma Screening***

We offer new and better technology to detect and diagnose GLAUCOMA at an ***earlier stage*** *than a typical eye exam will discover*. ***EVERYONE should consider this screening to get a baseline for future comparison.*  As a screening test, this is not a service covered by any medical or vision insurance plan.** T**here will be a low cost additional $15.00 fee for this testing due today.**

I would like to have the above test performed for a $15.00 fee \_\_\_\_\_\_ YES \_\_\_\_\_\_ NO (I accept the exam limitations to a diagnosis)

**Retinal Imaging**

You can request an 8 x 10 photo copy Retinal Image/picture of the inside of each eye for the low cost of $15.00. We will need to dilate your eyes to get the best quality. **You can choose both the Glaucoma screening and Retinal imaging for $25.00. (you save $5.00)**

I want an 8 X 10 retinal imaging for a $15.00 fee \_\_\_\_\_\_YES \_\_\_\_\_\_NO  **I want both tests for $25.00 \_\_\_\_\_\_YES**

1. Statements will be generated when your claims are internally processed or the balance exceeds the 45-day maximum allowance for outstanding balances. A statement may not be generated for balances due under $10, however these amounts will remain on your account and will be due on the next service date. ***Statement balance amounts will be due within 30-days of statement date.*** If you find an error on your statement or have any questions, please contact us immediately to clear up any confusion or concerns.
2. Appointments made are the responsibility of the patient or guardian to keep, cancel or reschedule in a timely manner. ***We required a 24 hour notice to move or cancel an appointment. No show or same day cancellations will incur a $40 Fee.***

## Credits & Overpayments / Returned Checks

1. Credits will remain on your account to be used for future visits unless you request those amounts be refunded to you. Overpayments will be refunded within 30-days upon written request to our practice. \*\*Credits under $5 can be refunded to the original credit card used only.
2. Returned checks will incur a *$35.00 service charge*. Payment for return checks and services are due upon the notice of the returned check and are payable by cash, money order, VISA/MC, Discover, Care Credit. Family Vision Care reserves the right to refuse payment by check if a history of returned checks is established.

All accounts not paid within 90-days of the due date may subject to dismissal from the practice and may be turned over to our contracted collections agency and documented on your credit report. Accounts reported to the credit bureau are subject to a collection fee with a maximum of $20 that will be added to your total balance due and will be your responsibility. Past due balances of over $200.00 may be taken to small claims court.

**FINANCIAL POLICIES**

1. Each new patient must complete a registration form prior to or at the time of his or her appointment. Registration forms are updated annually.
2. Proof of insurance and identity must be provided on the date of service. If this is not provided as is required by your insurance company AND our practice policies, the patient will be **expected to pay in full for all services when services are rendered.** If we are *unable to verify insurance benefits*, the patient will be **expected to pay at the time services are rendered.**
3. Out of pocket amounts are **due on the date of service.** Patient prescriptions, referrals, or any other services and materials to be rendered by our practice may be held until all outstanding balances are paid in full by the patient
4. Payments for services may be made by Cash, Check, Money Order, VISA/MC, Discover, Care Credit.
5. If we are filing a claim for you, your contracted exam co-payments, **coinsurance and deductible amounts will be collected at the time of service.**
6. Patients with outstanding balances must make payment arrangements before their next appointment with the doctor.
7. It is each patient’s responsibility to understand his or her insurance coverage. As your health care provider, our relationship is with you, not with your insurance company. ***While filing of insurance is a courtesy and service we extend to our patients, all charges are your responsibility from the date services are rendered***. Please always contact your insurance company for questions regarding your policies.
8. Verification of your insurance benefits is not a guarantee of payment. All payments are subject to the terms and allowances of your plan when claims are received and processed by your insurance company.
9. If we have not received a payment or a denial from your insurance company within 45-days of submission, we reserve the right to bill you directly for the services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature (***If patient is a minor, parent signature is required***) Date