Vision Institute

Today's Date: ________/________/_________ Nick Name: ____

Last Name: ____ First Name: _____________________________________ MI: ______

Sex: **Male** or **Female** (Please Circle) SS# (Needed for insurance billing):____________-_________-_____________

Primary Language: ___________________________ Race: ________________________ Ethnicity: ____________________________

Birthdate: _______/________/_________ Current Age: ___________ E Mail Address: ___________________________________

Mailing Address: ____Apt:______________________

City: ____ State: ______ Zip: __________

Preferred Pharmacy:____

Cell Phone #: ( ) ______-____________ Home Phone #: ( ) ______-___________ Work Phone # ( ) ____-____________

Married: _____ Partnered: _____ Single: ______ Separated: _____ Divorced: ____ Widowed: _____ Minor: ______

Patient's Primary Care Physician: ____

How were you referred to Vision Institute?____

Insurance Information: *(Even though we have scanned your insurance cards, we require that you still fill this out.)*

Person responsible for this account: _______________________________________ Relationship to patient: _____________

Person responsible for account date of birth: __________________Primary Holder SS#: _________-_______-__________

Primary Insurance Company: ____________________________ ID #: _________________________GRP #: __________________

Secondary Insurance Company: ___________________________ ID #: ____________________________ GRP #: _____________

Vision Plan Insurance Company: ____

Assignment and Release

I certify that I, and/or my dependents have insurance coverage with ____ and assign directly to Vision Institute/Simmons Eye Associates, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that **I am financially responsible for all charges whether or not paid by insurance**. I authorize the use of my signature on all insurance submissions. The above-named clinic may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or three years from the date signed below. If you have **MEDICARE**: I request that payment of authorized Medicare benefits and, if applicable, Medicaid/Secondary Insurance benefits, be made on my behalf to Vision Institute/Simmons Eye Associates, PC for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me, to release to the centers for Medicare/Medicaid/Secondary services and their agents, any information needed to determine these benefits or benefits for related services. I understand that I will be responsible for any missed appointments or any cancelled appointments in which a 24-hour notice was not given. There will be a fee of $35 for any missed office visits, $50 for any missed office procedures and $250 for missed surgery appointments. I understand that if I fail to pay the balance on account, this may result in Vision Institute pursuing any collection means possible. I understand that I have the opportunity to request the full financial policy at any time.

Print Name: _________________________Signature: _______________________________Date: _____/______/________

Vision Institute

Acknowledgement of Privacy Practices HIPAA

Patients Printed Name: ______________________________________ Birthdate: ____/_____/_____

We would like to inform you of the rights you have as a patient under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

Under HIPAA, I understand that my personal information may be used to:

- Provide and coordinate my treatment among several healthcare providers who may be involved in my care directly or indirectly
- Obtain payment from third-party payers for my healthcare services
- Conduct normal healthcare operations such as quality assessment and improvement activities

I have been informed of Vision Institutes Notice of Privacy Practices and understand that I may request a copy of this notice for my own use. I understand that Vision Institute has the right to change the Notice of Privacy Practices and that I may contact the office to obtain a current copy of the Notice of Privacy Practices at any time. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I further understand that Vision Institute is not required to accept my requested restrictions, but if they are accepted then I understand that Vision Institute will honor my request unless it is an emergency situation.

Authorization to communicate protected health information:

May we leave voicemail on: Cell: Yes______ No: _____ Home: Yes: _____ No: _____

In case of an Emergency who may we contact? ***(Know that this person will also have access to your health information)***

Name: ___________________________ Relationship: _____________________ Phone # :( ) _________-___________

Who may we share your health information with?

Name/Relation: _______________________________ their phone #: ( ) ________-__________

By signing below I acknowledge that I have been given, read, or offered a copy of Vision Institutes privacy policy and I understand that my information will be kept in my medical record and the instructions above and listed on the privacy policy will be honored until revoked by me in writing.

____ ______/______/______

Printed Name **Date of Service**

____

Patient Signature **(or person authorized to sign for patient)**

Vision Institute

MEDICAL VS. VISION EXAM

Patients Printed Name: ______________________________Birthdate: _____/_____/______

Health insurance can be very confusing to understand. One important clarification is the difference between a Medical Eye Exam and a Vision Exam. Insurance coverage for eye exams varies depending on diagnosis and treatments.

YOU ONLY CHOOSE ONE OR THE OTHER IN ORDER TO BILL TODAYS EXAM

Vision Plans- *Sometimes routine vision coverage can be separate from your medical insurance or included in it.*

- These are routine or "Well Vision" exams and your eyes will be examined for any needed correction/refraction (glasses or contact lenses) and **not eye disease or symptoms of disease.**
- Vision exams require an authorization from your vision carrier, which we will request on the date of service. Most vision plans require a copay and/or a portion of the contact lens exam and/or optical materials be paid by you on the date of service.
- **If we find a medical eye problem during your exam, you will need to return on a different date of service under your medical coverage for treatment.**

I understand the above and would ***like you to bill my vision plan*** *for today's services. I understand that I may be subject to a copay, and/or a portion of the contact lens exam and/or optical materials be paid by me on the date of service.*

__________________________________/______________________________/________________

Sign Name **Print Name** **Date**

Medical Exams- *This is the same insurance you would use at your regular doctors or emergency room.*

- This is a medical examination for the diagnosis and treatment of diseases and conditions of the eye performed by a physician/surgeon.
    - This includes but is not limited to: cataracts, glaucoma, diabetic retinopathy, macular degeneration, dry eye disease, allergies, and many other potentially sight-threatening diseases.
- When we bill your medical insurance, you will most likely be subject to a copay, deductible, or co-insurance. This depends on your contractual agreement with your insurance company.
- NOTE: Most medical plans will not cover the refraction portion of the exam.

I understand the above and would ***like you to bill my medical insurance*** *for today's services. I understand that I may be subject to a copay, a portion of my yearly deductible, or a co-insurance amount.*

__________________________________/______________________________/______________

Sign Name **Print Name** **Date**