

# Eye to Eye Care

## Drs. Rafael & Jennifer Borges

### Welcome to Our Office

Patient Name (Last, First Middle)		Sex: M / F	Today's Date / /
Address (Number, Street, Apartment #)		Birth date / /	Age
City	State / Zip	Social Security #	
Employer/School	Occupation/Grade	Home Phone # ( )	
Parent/Spouse Name	Financially Responsible	Work Phone # ( )	
E-mail Address		Cell Phone # ( )	
Family members who are patients at this office	How did you hear about this office?	Referred By: (check one) ____ Dr. ____ Patient ____ Other: _____	
Family Physician name & Location	Previous Eye Doctor's Name	Date of Last Eye Exam / / Were you dilated? YES NO	
Do you work on a computer? How Often?	Hobbies/Special Interests	Are you interested in LASIK? Yes No	
Do you authorize for our offices to release your glasses, contact lenses, or prescriptions to any person other than yourself? Who?  Yes No Name(s): _____	Please indicate the name of your Insurance/Benefit program: (circle one) VSP VC-comp benefits Eye Med Aetna Cigna United Healthcare	Please circle your preferred method of payment Cash Master Card Discover Visa Debit/Check American Express	

**IMPORTANT INFORMATION REGARDING "ROUTINE" VISION EXAMS (PLEASE READ!!)**

*Many patients visiting our practice will be using "routine" vision exam benefits contracted through a vision insurance carrier. A "routine" vision exam is defined (by your vision insurance carrier) as an exam of normal, healthy eyes, with a refractive error, (near sightedness, far sightedness, astigmatism, etc.). However, if the doctor detects a medical condition, or a disease process, either through diagnostic testing or during the process of the exam, the exam is no longer considered "routine".*

*At this point, the exam becomes medical in nature, and these findings will be documented in your health record with the appropriate medical diagnosis. Medical exams are filed with your health insurance carrier, and we will need to collect your specialist office visit co-pay at the time of service. If you have any further questions about this information, please contact our insurance department. Thank you!*

# EYE TO EYE CARE PATIENT POLICIES

## INSURANCE INFORMATION

1. **INSURANCE IDENTIFICATION AND YOUR DRIVERS LICENSE** *must* be presented **BEFORE** the examination.
2. **PRIOR AUTHORIZATION** from your insurance company is required before services are rendered.
3. Your claim cannot be processed without **VERIFICATION** of **ELIGIBILITY** by our office **PRIOR** to your exam.
4. Please understand that **YOU** are financially responsible for all services not covered by your insurance company.
5. We ask that you be prepared to pay your portion of the exam (co-pay) at the time services are rendered.

## APPOINTMENT POLICY

There will be a \$20.00 fee charged to patients who do not give 24 hours notice for cancellations and/or do not show for their scheduled exam appointments.

## OUR PAYMENT POLICY

- Fees are due at the time services are rendered.
- A \$25.00 administrative fee will be charged on ALL returned checks. Exam and/or Contact Lens Fees are **NOT** refundable.

## **OUR PROMISE OF PRIVACY AND CONSENT TO PATIENT RECORDS (HIPAA)**

***Our office is committed to compliance with the HIPAA guidelines by:***

1. *Providing appropriate security for our patient records.*
2. *Protecting the privacy of our patient's information.*
3. *Providing our patients with proper access to their records.*
4. *Appropriately maintaining our patient information and billing processes in compliance with national HIPAA standards.*

*Complete HIPAA compliance will be furnished upon request. If you ever have any questions or concerns about your services or charges, we encourage you to call and ask our Office Manager.*

## ***Signature Authorization (please initial each statement after reading)***

\_\_\_\_ I understand my health insurance carrier will be billed if my routine vision exam becomes medical in nature, and I understand I will be responsible for any applicable co-pays, deductibles, etc.

\_\_\_\_ I acknowledge that I have read and fully understand Eye to Eye Care's Patient Policies, (the information listed above regarding appointments, insurance and payment policies), and conditions thereof. I also understand I am financially responsible for any service not covered by my insurance plan, and that payment for non-covered services is expected at the time of service. I understand that if any unpaid balance on my account is sent to a collection agency, I will be responsible for all fees associated with collection of the debt.

\_\_\_\_ I acknowledge that all information in my medical record is confidential and may be handled by the support personnel of Eye to Eye Care and Drs. Borges Enterprises, Inc.

\_\_\_\_ I authorize the release of my medical information to the third party organization that is necessary to process claims for services rendered.

\_\_\_\_ I authorize the payment of my medical/vision insurance benefits to Eye to Eye Care or to any party who accepts assignment for all services provided.

\_\_\_\_ I have received a copy of the HIPAA Notice of Privacy Practices.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_