LOOKING GLASS EYE CENTER PATIENT REGISTRATION

PATIENT INFORMATION
AUTHORIZATION TO RELEASE HEALTH INFORMATION
FINANCIAL POLICY

Name: ____ **Date of Birth:** ________________
(First) (Last) (MI)

Address: ____
(Street) (City) (State) (Zip)

Cell # ______________________ **Landline #** ______________________ **Work #**______________________

Email: ____ **Sex:** M F

Marital Status: Single Married Divorced Widow Other **Language:** ______________________

RESPONSIBLE/BILLING PARTY IF DIFFERENT FROM ABOVE
(Must complete if patient under 18)

Name: _____________________________________ **Phone #:** ________________________________
DOB: _______________ **Address: ( ) Same as above** **Relationship: Parent Guardian Other**

____
(Street) (City) (State) (Zip)

RACE: *White _____ *Black/African American _____ *American Indian/Alaska Native____ *Decline to Answer ____
ETHNICITY: *Not Hispanic/Latino ____ *Hispanic or Latino ____ *Decline to Answer ____

COMMUNICATING WITH YOUR FAMILY, FRIENDS, OR CAREGIVERS
PLEASE MARK #1 OR #2. FILL OUT THE INFO ON #1.

1.___This practice may orally communicate to the family members, friends, or caregivers listed below. You may release appointment information, billing/insurance, prescriptions, test results, etc.

Spouse/Partner: _________________________ Phone: ______________________ Emergency: YES NO
Other: ________________________________ Phone: ______________________ Emergency: YES NO
Other: ________________________________ Phone: ______________________ Emergency: YES NO

May we leave a voicemail: YES NO

2.___This practice may NOT communicate with my family members, friends or caregivers.

*You can revoke or stop the communications on this form at any time in writing. It will not apply to any communications that were made before our practice received your written notice to stop.

INSURANCE INFORMATION

Medical Insurance: ________________________________	Vision Insurance: ____________________________
ID/Policy #____	ID/Policy# _________________________________
Primary Insured Name: ____________________________	Primary Insured Name: ______________________
Insured Date of Birth: _____________________________	Insured Date of Birth: _______________________
*Social Security# __________________________________	*Social Security# ____________________________
Relationship to Insured: ___________________________	Relationship to Insured: _____________________

*Some insurance companies require a social security number to look up benefits.

BLUE MEDICARE ADVANTAGE NC MUST INDICATE MEDICAL OR VISION EXAM

FINANCIAL POLICY AND NON-COVERED SERVICES

FORMS OF PAYMENT: We accept cash, check, debit, major credit cards (Visa, MC, Discover only), CareCredit.

MEDICARE: We accept Medicare assignment. Medicare pays 80% of approved charges and you or your supplement is responsible for the remaining 20%. You are also responsible for any non-covered charges like refractions (glasses prescription), contact lens fitting fees, and your Medicare deductible.

MEDICARE ADVANTAGE, HMO, PPO, COMMERCIAL INSURNACE: All co-pays are due at the time of service. You are responsible for verifying what your insurance will cover before your exam and if we participate in your plan.

VISION PLANS: We participate in the following vision plans: VSP, EYEMED, SUPERIOR VISION, SPECTERA (UHC VISION), COMMUNITY EYE CARE, MARCH VISION, NVA, PREMIER EYE CARE, ALWAYS CARE, AVESIS, AMERIHEALTH, ENVOLVE VISION. Vision plans cover only ***routine screening for glasses or contact lenses.*** Medical exams are not covered. Check your vision plan to see if we participate in your policy.

REFRACTIONS: This test determines the eye's prescription and need for corrective lenses. Also known as your glasses prescription. Your glasses prescription expires every year and needs to be updated regardless if there are any changes from the year before. This charge is covered by vision plans but not medical insurance. **The charge for this test is due at the time of service in order to release a copy of your prescription.**

$40.00: Refraction fee

CONTACT LENS FITTING FEES: Contact lens prescriptions expire every year and are a separate charge from the exam charge. The contact fitting fee is the charge for verifying the size or base curve of your eye and power of your prescription. Also, verifying the brand of contacts and if you require soft or hard contacts. The price varies as outlined below and covers any follow-up exams at no charge.

$40.00: Currently wear contacts and have no change

$50.00: Currently wear contacts that require a straightforward change in prescription

$90.00: New fit contacts or significant change in contacts requiring multiple trials/fittings

$150.00: Soft Multifocal, Toric or Multifocal Gas Perm contacts

$250.00: Keratoconus fitting

***Up to $2,700: Schleral contacts**

$30.00: Additional charge for any insertion and removal training

*Price may vary depending on prescription.

PLEASE CIRCLE ALL PREFERRED CONTACT METHOD FOR REMINDERS

Text Message   Phone/Voicemail   Email   No reminders

PLEASE READ AND SIGN THE ACKNOWLEDGEMENT OF THE FINANCIAL STATEMENT AND RELEASE OF INFORMATION

I authorize Looking Glass Eye Center to release any information relating to an illness, injury, diagnosis or care of treatment to my insurance company for any claim related information. Such information shall include, but is not limited to, any medical records and medical information. I understand that the reason for furnishing such information may include use in medical, financial or provider auditing.

I attest I have disclosed all active insurance and agree the proper information is on file with my provider. I understand Looking Glass Eye Center will file my insurance and I am responsible for any co-pays, co-insurance, deductible and non-covered charges.

Signature:____ Date: ______________________