Welcome to Elite Eye Care!

-Jessica Keller, O.D.

How did you hear about or choose our office?

- ☐ Friend or Relative
- ☐ Another Doctor
- ☐ Insurance List
- ☐ Saw Sign/Building
- ☐ Online Search. If so, what site? ______________________
- ☐ Other: ____

Patient Information

First: __________________________________ Middle: __________________ Last: ________________________________

Preferred nickname: ________________________ Parent's name (if minor): ____________________________________

Address: ____

City, State, Zip: ____

Date of Birth: __________________ Sex: M or F (please circle) Email: ______________________________________

Phone #1: ( )____________________ (cell/home/work) Phone #2: ( )__________________(cell/home/work)

How do you prefer to be contacted? (please circle) Cell # Text Home # Work # Email

Employer (or School): ____________________________ Occupation: _________________________________

NOTICE OF PRIVACY PRACTICES- ACKNOWLEDGEMENT:

We keep a record of the health care services we provide to you. We will not disclose your record to others unless you direct us to do so or unless legal authorities authorize or compel us to do so. You may request a copy of your medical records or get more information by contacting the Elite Eye Care Privacy Officer. Our Notice of Privacy Practices is available at the reception desk. The Notice describes in greater detail how your health information may be used or disclosed, and how you can access your information. You are entitled to a copy of this Notice and it is available at your request.

☐ I acknowledge the Notice of Privacy Practices has been offered to me and is readily available in accordance with the Health Insurance Portability and Accountability Act. I have read or had explained to me prior to any services offered Elite Eye Care's Notice of Privacy Practices and agree to continue my care with Elite Eye Care under said terms.

Patient/Guardian: ____ Date: ____________________________

OFFICE USE ONLY:

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below or the patient's guardian was not present.

Date:	Initials:	Reason/Details:

FINANCIAL POLICY

FINANCIALLY RESPONSIBLE PARTY:

WHO IS RESPONSIBLE FOR THE ACCOUT?

Name: ________________________________ **Relationship to patient (or Self):** _____________________________

Date of Birth: _________________________ **Email:** ____

Address: ____

City: _______________________ **State:** _____________ **Zip Code:** _____________

Cell Phone: ______________________ **Phone #2:** ______________________ **(Preferred Phone#: Cell, Home, Work)**

Payment options: Cash, Check, Visa, MasterCard, American Express, Discover, Care Credit.

Please note: It is customary to pay for professional services when rendered. However, if you have a medical problem then we will bill your insurance on your behalf. A refraction is a measurement of the lens power necessary to prescribe eyeglasses or other corrective lenses. Most medical insurance plans, including Medicare, do no cover routine refractions or routine eye exams (when no medical eye problem is known or suspected). Medicare, and most other insurance plans, insists that we charge separately for that portion of the examination since it is not a covered service. You will receive an explanation of benefits from them itemizing your responsibilities. **You will be responsible for any co-payments, deductibles, or non-covered services as determined by your insurance company.** If you have a separate plan that covers routine or annual eye examinations and/or materials, please let us know. Your vision plan may assist you with your eye care needs that are not covered by your medical plan. We will bill your vision plan as above. **In accordance with our contract and with your insurance provider, we are responsible for collecting, and you are responsible for paying, co-payments at the time of service.**

All patient statements will be mailed and payment will be due the 1st day of the following month. Statements will be sent accordingly for a 90-day period. Any unpaid invoices after 90 days will then be sent to collections (Credit Bureau of Bismarck, Inc.). Failure to keep your account current may result in our clinic being unable to provide wellness vision services, except for ocular emergencies, and/or material purchases (such as eyeglasses or contact lenses).

PAYMENT IS REQUIRED AT TIME OF ORDER FOR EYEGLASSES/CONTACT LENSES.

NO REFUNDS OR EXCHANGES ON CUSTOM ORDERS.

Patient/Guardian: ____ Date: ____________________________

INSURANCE INFORMATION

***Primary Vision Insurance:* ____**

Primary Vision Insurance Policy Holder: Name: _____________________________ DOB: _____________ Last 4 SSN: __________

(If different) Address: ____ Phone: ________________________

Primary Vision Insurance Policy/ID Number: ____

Primary Vision Insurance Phone Number: (on back of card) ____

Primary Vision Insurance Address: ____

***Primary Medical Insurance:* ____**

Primary Medical Insurance Policy Holder: Name: ___________________________________ DOB__________________________

(If different) Address: ____ Phone: ________________________

Primary Medical Insurance Policy/ID Number: ____

Primary Medical Insurance Phone Number: (on back of card) ____

Primary Medical Insurance Address: ____

Does your medical insurance have a benefit for a wellness eye exam annually? Yes or No (please circle)

*Medical insurance is requested as any eye infection, eye injury, or medical eye condition can/will be billed through your medical insurance.

AUTHORIZATION TO BILL INSURANCE: I authorize Elite Eye Care to bill my insurance carrier on my behalf. I request that payment of authorized insurance benefits be made to this clinic for any services furnished to me by this doctor/clinic. I understand that I am financially responsible for any balance not covered by my insurance carrier, and that a quotation of benefits is not a guarantee of coverage. A copy of this signature is valid as the original. I authorize any holder of medical/vision to release any information needed to my medical/vision insurance carrier to determine the benefits payable for related services for myself and/or my dependents.

Patient/Guardian: ____ Date: ______________________________