ELITE EYE CARE

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 & INSURANCE INFORMATION

FINANCIALLY RESPONSIBLE PARTY: WHO IS RESPONSIBLE FOR THE ACCOUNT?

Name: _____ **Relationship to patient (or Self):** _____

Date of Birth: _____ **Email:** _____

(If Different) **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 be responsible for any co-payments, deductibles, or non-covered services as determined by your insurance company.** 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:

Please give both your MEDICAL AND VISION INSURANCE CARDS**/information to our front desk associate and they will scan and confirm your insurance information.** We prefer to have both your vision and medical insurance information, so that we can file to the correct insurance depending on the type of examination.

Initial: _____

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:** _____