Marion Eye Center **PATIENT INFORMATION** **Delaware Eye Center**

Today's Date: _____ Cell Phone: _____ Home Phone:_____

Patient Name: _____

Last Name First Name Middle

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ SS#: _____ Gender: Male Female

Marital Status: Single Married Widowed Email: _____

Business Name & Address: _____

Business Phone: _____ Occupation: _____

Spouse/Responsible Party/POA ( ) mark here if self

Name: _____ Relationship to patient: _____

Date of Birth: _____ SS#: _____

Primary Insurer: _____ Secondary Insurer: _____

Primary Physician: _____ Optometrist (glasses doctor): _____

Name of Pharmacy: _____ **Location**: _____

Who do we have to thank for your referral to our office: _____

Marion and Delaware Eye Centers are authorized to release information to the following person(s):

Name_____Relationship_____ phone_____

Name_____Relationship_____ phone_____

ASSIGNMENT & RELEASE – General and Secondary Insurances

I, the undersigned, have insurance coverage with: _____,
And assign directly to Marion Eye Center, Inc. and Delaware Eye Center, all medical 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all current and future insurance submissions.

_____ _____

Signature of Insured or Guardian Date

ASSIGNMENT & RELEASE – Medicare

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Marion Eye Center and Delaware Eye Center for any services furnished me by their physicians. I authorize any holder of medical information about me to release to the CMS (Centers for Medicare & Medicaid Services) and its agents, any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated on item 9 of the HCFA-1500 Performa, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. For Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature of Insured or Guardian Date

SECTION A – General Information

MEDICATIONS: ____See list below ____See Photocopy ____Contact Primary ____Unsure of Meds

Medication Name	Dosage	Frequency

List any medication allergies:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY: Do you currently smoke? Yes No Are you a former smoker? Yes No

Have you been diagnosed with? (circle all that apply): Diabetes High Blood Pressure Thyroid Disease

Asthma Stroke Hepatitis Tuberculosis HIV/AIDS COPD/Emphysema Cancer

Seizure Disorder/Epilepsy Heart Disease Other:_____

FAMILY HISTORY: (circle all that apply)

Glaucoma Diabetes Macular Degeneration Other eye problem: _____

SECTION B – If you are a New Patient or have New Problems to report

1. Which of the following problems have you noticed or been told you have by another doctor? (circle all that apply)

Blurred reading vision	Eyelid problem	Cataract – Glare – Halos
Blurred distance vision	Eye redness	Glaucoma
Double vision	Itching/Allergies	Diabetes
Distorted vision	Floaters/Flashes	Other: _____
Tearing	Crossed eyes	_____
Dryness	Need new glasses	

2. Previous eye problems you know of:

Lazy eye (amblyopia) Right eye Left eye

Eye surgery or injury: _____

Other eye disease: _____

MARION AND DELAWARE EYE CENTERS FINANCIAL POLICY

We are dedicated to providing the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

INSURANCE COVERAGE

It is the patient's responsibility to provide us with accurate information for billing their health plan properly. It is also the patient's responsibility to know whether their visit with us is covered by their health plan fully, partially, or not at all, and whether their plan requires them to obtain a referral from their primary physician before their visit with us. Information of this type is 100% accurate only if you obtain it directly from your health plan – not from us. In the event the patient does not confirm this information and their insurer refuses full or partial payment, the cost of our services will be due from the patient personally. We have made prior arrangements with many health plans for payment submission by agreeing to their discounted fee schedules. It is our responsibility to properly submit claims to these particular insurers, but not those with whom we have no relationship. Therefore, we will bill only those plans with which we have an agreement. The patient should call their insurer or check their insurer's published list of covered doctors to determine whether an agreement exists between Marion Eye Center and Delaware Eye Center and their health plan. This will clarify whether our office may submit claims for the patient.

AMOUNTS DUE FROM THE PATIENT

Unless other arrangements have been made in advance by either the patient or their health coverage carrier, full payment is due at the time of service. Therefore, patients should bring means of payment to each appointment. Extra fees may apply if amounts due are not collected at the time of service. For patient convenience, we accept VISA, MasterCard and Discover. Any insurance co payment or deductible will be collected from the patient at the time of service. Any amounts determined "not covered" or "denied" will be billed to the patient after we receive such notification. If we do not participate in a patient's insurance plan, the patient is to provide payment for care and treatment at the time of service. In such a situation, we will provide a statement of services and a receipt for amounts paid which they may submit to their insurer. In this case, the insurer is responsible for reimbursing the patient.

AMOUNTS DETERMINED "NOT COVERED"

In the event a health plan determines a service of ours to be "not covered", the patient will be responsible for the complete charge. An important example of this is our charge for checking eyes for changes in glasses prescription (a procedure called "refraction") or a contact lens exam. Our charge for these services varies by complexity and is not covered by most insurers we currently have agreements with. Please make note of this, as it has historically been an area of misunderstanding with our patients: **If the doctor checks the eyes for changes in glasses, the patient is likely responsible for this amount personally.**

DELINQUENT ACCOUNTS

Should you fail to pay your bill after receiving a past due statement or fail to follow through on an agreed upon payment plan, your balance will be sent to an outside collection agency and you will be responsible for the fees assessed by the collection agency in addition to your account balance. Furthermore, once sent to collections, we will not be able to see you in our office until your balance has been paid in full.

SURGERY AND LASER SERVICES

As a courtesy, and because of the complexity involved, we will be happy to bill any health plan for all surgical services we provide, whether or not we have a relationship with them.

MINOR PATIENTS

A parent or legal guardian MUST accompany all minor patients on their initial visit to the Marion Eye Center and Delaware Eye Center. For all services rendered to minor patients, the adult accompanying the patient is responsible for presenting proper insurance information, obtaining any necessary insurance pre-approvals, or providing payment in full at the time of service.

MISSED APPOINTMENTS

We strive to be available to those who need our services as quickly as possible and missed appointments limit our availability to other patients. Should you need to cancel or change your appointment, please notify us as soon as possible. If you fail to show up for your visit or cancel 24 hours in advance, you may be subject to a cancellation fee. (Please review our cancellation policy for further details)

CONTACTING YOU

You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I have read and understand the financial policy of the Marion Eye Center and Delaware Eye Center and agree to be bound by its terms. I agree that the Marion Eye Center and Delaware Eye Center may contact me as noted above. I also understand and agree that such terms may be amended from time to time by the practice.

Signature of Patient or Responsible Party if a Minor: _____ **Date:**_____

MARION AND DELAWARE EYE CENTERS
Cancellation, No Show, & Late Arrival Policy For Doctor Appointments

Our Goal:

To provide timely, high quality care to all of our patients. This policy is designed to limit same day cancellations and no shows to enable us to utilize available medical appointments to care for our patients. We understand there are times when you will miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, this prevents other patients from getting scheduled for their needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment schedule and this will delay your evaluation and care.

Description:

"No Show" shall mean any patient who fails to arrive for a scheduled appointment. "Same Day Cancellation" shall mean any patient who cancels an appointment less than 24 hours before their scheduled appointment. "Late Arrival" shall mean any patient who arrives 15 minutes after the expected arrival time for the scheduled appointment.

Our Policy/Charges:

If it is necessary to cancel or change your scheduled appointment, **we require that you notify by calling one of our offices at least 24 hours in advance.** Appointments are in high demand and your early cancellation will give another patient the opportunity to have access to timely medical care.

- Same Day Appointment Cancellation / No Show: $25.00 – this will not be covered by your insurance company and will be subject to being sent to collections if not paid

- Three (3) documented Same Day Cancellations or No Shows: Patient may be subject to dismissal from the clinic and we may no longer be able to provide you with care

- 15-Minute Late Arrival: We will do our best to work you in to the schedule that same day, but your appointment may need rescheduled to another date

Patient or Responsible Party Name (print name): _____

Signature of Patient or Responsible Party: _____

Responsible Party Relationship to Patient (if applicable): _____

Date: _____

MARION AND DELAWARE EYE CENTERS
NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. **You have the right to review our Notice before signing this Consent. Please ask the Receptionist for a copy of our Notice Summary and/or the full Notice of Privacy Practices.** The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

Patient or Responsible Party Name (print name): _____

Signature of Patient or Responsible Party: _____

Responsible Party Relationship to Patient (if applicable): _____

Date: _____

Witness: _____

MARION AND DELAWARE EYE CENTERS
BILLING AND COMMUNICATION PREFERENCES

BILLING PREFERENCE Failure to select an option will result in mailed statements

Our office can send **Billing Statements and Balance-due Reminders** electronically or by mail. Please provide the necessary information below to indicate your preference for how you would like to receive statements. *We highly recommend an electronic option*. (PLEASE SELECT ONE OPTION)

(Option 1) by Email → Enter email address _____

(Option 2) by Text → Enter phone number _____

(Option 3) by Mail → Address _____

City _____ State _____ Zip _____

COMMUNICATION PREFERENCE Failure to select an option will result in phone call reminders

Our office can send **Appointment Reminders** electronically or by a phone call. Please provide the necessary information below indicating your preference. *We highly recommend an electronic option*. (PLEASE SELECT ONE OPTION)

(Option 1) by Email → Enter email address (if different from above) _____

(Option 2) by Text → Enter phone number (if different from above) _____

(Option 3) by Phone Call → Enter phone number _____

Patient name (print):_____

Note: Failure to select any options above will result in mailed statements (option 3) and phone call reminders (option 3) being utilized until we are notified of any preferred changes.