Parker Family Eye Care, OD PLLC Today's Date________________

Name: ____ Gender: □ Male □ Female
Address: ____ Home Phone: _______________
____ Work Phone: ______________
Birth Date: _____/____/____ SS#: _____/____/______ Email: _____________________________________
Occupation: ____ Employer: _________________________________
Emergency Contact: ________________________ Home Phone: ______________Medical Dr.______________________

Financial Policy: We are pleased to have you as our patient, and we are committed to providing you with our best professional care. Your understanding of our Financial Policy is important to our relationship. Please ask us if you have any questions.

Insurance: Due to all the various plans now in effect, we require that you check with your insurance carrier(s) regarding our participation in your specific network. There are instances when even though we are contracted with a carrier, the carrier has networks in which we do not participate. If our office does not participate in your network, you will be responsible for a large portion of or the entire bill. The carrier contact information is on the back of your insurance card. It is your responsibility to update us with any new card that you receive from your carrier. For all insurances that we are participating providers, we will send your insurance carrier a claim for all services provided. You will be billed for any balance due after the carrier settles your claim.

Payment Expectations: If you are not covered by insurance, you will be required to pay for your services on the date the service is received. All patients are required to pay co-payments, deductibles and co-insurance at the time of your visit. You will receive a statement from our office after your insurance has settled your claim if there is any balance due. Payments are expected within thirty days of receipt of the statement.

Refraction Fee: Refraction is the measurement of glasses prescription for the purpose of prescribing new glasses or determining the best-corrected visual potential of the eye. Medicare and many private medical insurance carriers do not cover this service and require a separate charge apart from the medical part of the exam. Some supplemental insurance carriers will reimburse this fee. You will need to contact your insurance carrier to find out if and how they cover this service. You will be given a receipt of this service if performed. **REFRACTION is the process by which glasses and contact lenses are prescribed as part of regular eye examination if not considered medically necessary by Medicare and other insurance carriers, it can be charged a standard fee of $40.**

Eyeglasses: Our eye glasses are properly manufactured and triple checked with exceptionally professional optical labs, as well as our on staff opticians confirming lens materials, lens options and treatments and frame options. Since your prescription is unique to only you: we do not issue refunds on glasses and we do not exchange frames should you change your mind about your selection. If there is an error or mistake upon ordering from the lab, we will make that right at no charge to you. If Dr Parker should change your prescription upon your request, we will ask your lab if there will be fees associated and let you know before charging you if at all.

Payment for all medical services is the responsibility of the patient and is expected at the time of service. I agree to pay all attorney fees, court costs, filing fees, including charges or commissions up to 50% that may be assessed to me by any collections agency retained to pursue this matter. I further agree to pay any interest at the rate of 3% per month on any delinquent balance. I understand there is a **$35.00 service charge for all returned checks.** I hereby authorize the release of medical information concerning my illness and treatment by this clinic to my insurance company, and the Health Care Financing Administrations or its agents. I also authorize release of my personal medical information to any doctor to whom I may be referred for a consultation. I authorize payment of medical benefits to the provider or facility. I understand that any other information about me including prescriptions for glasses or contact lenses, will not be released to anyone else without my written consent. I hereby authorize any procedures, including dilation of the eyes, as may be deemed necessary for my care. I also grant permission for treatment if this patient is a minor.

____ __________________
Signature of patient or legal guardian

ABN, Insurances, & Self-Pay Acknowledgments for Parker Family Eye Care

Patient Name: ____________________________ Date of Birth: __________EMAIL___________________________

Military Sponsor____________________________ Date of Birth:_______________SSN_________________________

ACKNOWLEDGEMENT OF PRIVACY POLICIES (HIPAA): I acknowledge that I can request a copy of this office's Notice of Privacy Policies, or I may read the office copy while I wait to be seen.

24 HOUR CANCELLATION & NO SHOW POLICY: Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, PFEC reserves the right to charge a **$25 fee** for all missed appointments & no shows without compelling reason & not canceled with a **24 hour notice**. **Patients will be charged $25 no show fee upon their first missed appointment not canceled within 24 hours and this fee will be required to be paid before a new appointment can be made.**

___ I **DO NOT ALLOW** Parker Family Eye Care to keep my credit card information on file.
___ I **ALLOW** Parker Family Eye Care to keep my credit card information on file. I acknowledge and understand that this card may be automatically charged for any outstanding balances after appointments unless otherwise stated by the patient.

INSURANCE AUTHORIZATION: I request that payment of authorized insurance benefits for any service furnished to me, be made on my behalf to Parker Family Eye Care, OD, PLLC (PFEC). I authorize PFEC to release any medical records about me to my insurance company that may aid in determining benefits or payments. **I understand that I am responsible for charges not paid by the insurance plan.**

CONTACT LENS: I understand that there will be a fee in order to receive and/or maintain a valid prescription for contact lenses. Some insurance plans will cover a portion of a yearly fitting fee. The fee will be determined by the doctor based on the complexity of the prescription as well as what your insurance dictates upon retrieval of authorization. Included in the visit price are 2 followup visits to troubleshoot any issues with the contact lens prescribed. Any further followup visits will be charged an additional visit fee. ****PLEASE NOTE** ANY contact fitting that does not receive a call back to our office within 5 business days is aware the prescription is NOT FINALIZED. Any contact fitting 60 days PAST original exam date can be charged a fee varying between $85.00 - $145.00**

Patient/Guardian Signature:___________________________________ Date: ____________________

SELF PAY Routine Exam Patients ARE $145 (new patient), $140 (established) for medical exam which includes refraction for glasses and Optomap retinal photos. SELF PAY Contact Lens Fittings VARY depending on what you wear & any material changes. The cost is in addition.

RETINAL PHOTOS: are a part of the Comprehensive Medical exam. They are similar to x-rays at a dental office, yet more in-depth. Retinal photos ARE Medical Treatment. **The fee is $40**. They are digital images of the retina which helps evaluate ocular health and detect problems unrelated to the eye. Medical insurances MAY NOT cover; some vision plans will cover but at a higher rate. **Check One:** _______ **Patient wishes to receive OPTOS (For $40 Fee)** _______**Patient denied OPTOS**

NON-COVERED SERVICES:
By signing below, I acknowledge I have read and understand all information stated above about my appointment. I acknowledge that I have been notified by my physician that the services identified may not be covered for reasons stated. I agree to be personally and fully responsible for payment. I understand that my doctor may order a more in depth version of these tests if medically necessary.

Patient/Guardian Signature: ___________________________________ Date: ____________________

ADVANCED BENEFICIARY NOTICE (ABN):
I authorize the following individual(s) to request and receive any Protected Health Information regarding my treatment, payment, or administrative operations. I understand that the identity of this individual must be verified before the release of any information.

Name: ____ Telephone:_____________________
Name: ____ Telephone:______________________
The above people are authorized to have information about my:
____ Medical Information ___ Billing Information ___ Scheduling Information ___ ALL
If necessary, is Dilation permitted for this patient? Yes ____ No ____ Height______ Weight______