Adventures IN EYE CARE
Vision Source

Annual Patient Update

Patient Information:

Name (Last, First, M)_____

Address_____City_____State_____Zip_____

Phone # (Home)_____ (Cell)_____(Work)_____

Drivers Licenses #_____Email Address_____

Occupation_____ Employer_____

Parent/Guardian Information (if patient is under 18 – must be accompanied by parent or legal guardian)

Name (Last, First, M)_____Date of Birth_____

Mailing Address_____City_____State_____Zip_____

Phone # (Home)_____ (Cell)_____(Work)_____

Social Security#_____-___-_____ Drivers License #_____Email Address_____

Alternate/Emergency Contact: (Is there anyone we can contact regarding your health and account information if you are unable to be reached?)

Name (Last, First)_____ Phone #_____

Can we disclose account information:_____Yes_____No, health information:_____Yes_____No

Insurance Information:

Insurance Company:_____Subscriber Name:_____

Subscriber ID:_____Group ID:_____

Subscriber Birthday:_____Patient Relation to Subscriber_____

Financial/Insurance Policy: Patients are responsible for all charges regardless of insurance coverage and are responsible for pre-authorizations and referral forms required for payment. Adventures In Eye Care will not become involved in disputes between you and your insurance company regarding deductibles, covered charges and usual and customary fees. Co-payments and deductible are due at time of service.

Authorize and Acknowledge: I understand it is my responsibility to confirm my coverage with my insurance and that Adventures In Eye Care may bill my insurance as a courtesy to me. I also authorize payment of insurance benefits directly to the doctor. Amounts not paid by insurance are my responsibility. I also acknowledge that my eyewear purchase is custom ordered. There will be no refund for services or products and orders cannot be canceled once they have been placed. Orders not picked up within 60 days may be returned and deposits lost.

I, the patient/guardian, have accurately and truthfully completed the patient information list above. I agree that all fees incurred are my responsibility regardless of insurance coverage.

Patient Name_____ Signature(patient/guardian)_____Date_____

HIPAA Notice of Privacy Pracitices: Adventures In Eye Care is required by law to maintian the privacy of, and provide individuals with, this notice of legal duties and privacy practices with respect to protected health information. Signature below is only acknowledgement that you have received this notice of our Privacy Practices:

Patient Name_____ Signature(patient/guardian)_____Date_____

Adventures
IN EYE CARE

Adventures In Eye Care (AIEC) Financial Policies
Please Read and Initial

PATIENT NAME_____ DATE_____

- If proof of insurance/eligibility cannot be provided, payment will be due in full. _____
- AIEC will collect any deductibles, copay, or coinsurance on the date of service. _____
- Insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-pays, covered charges, secondary insurance, "usual and customary" charges, etc. _____
- Please be advised, if you are here for a routine eye exam and have medical eye problems you want to discuss with the provider during your routine eye exam, this could result in an additional charge, which may not be covered by your vision insurance. For clarification or to update the reason for your visit, please see the front desk. _____
- Eyeglasses and contact lenses are custom made and custom ordered for you, therefore, are nonrefundable. _____
- Balances on your account must be paid in full before you will be seen again unless a payment arrangement has been made with billing personnel. If you need an arrangement, please contact the billing department in a timely manner as any claim over 90 days will be due in full. _____
- Statements are not generated for an amount due of less than $5.00; please watch your insurance explanations to see if you owe a balance. _____
- AIEC is in network with the following insurances: Medicare, Medicaid, Blue Cross, Tricare, Aetna, Cigna, and VSP. If your insurance is not one of these, please be aware your claim(s) may be processed as "out of network" or we may not be able to bill them at all, i.e. Spectera and Eyemed. _____
- Delinquent account (>90 days) are subject to collections processes which may include the account being transferred to Cornerstone Credit Services (CCS). Patients whose accounts have been sent to CCS will be reviewed for possible discharge from the clinic. _____
- AIEC will charge a fee of $30.00 for any checks returned at NSF. The patient's account will be flagged until the debt has been repaid. _____
- Any appointment cancelled less than 24 hours prior to the scheduled appointment time and no-shows will incur a $50.00 cancellation fee. After three missed appointments, an account will be reviewed for discharge from the practice. _____
- It is important to clarify the reason for your visit. Please do this at the time of your visit as it is AIEC's policy to not change a diagnosis code after the visit. Do feel free to clarify/confirm what diagnosis will be used with your provider before you leave the office. _____