* * * PATIENT INFORMATION UPDATE* * *

Please fill in the following information: (Please Print)

NAME_____ TODAY'S DATE_____/_____/_____
LAST FIRST MIDDLE INIT. TITLE

DATE OF BIRTH_____ AGE_____ SEX: M F

ADDRESS_____
STREET ADDRESS AND PO BOX CITY STATE ZIP

TELEPHONE (HOME)_____(CELL)_____
(WORK)_____

Email Address:_____

Is it Okay to Text You? YES____ NO____

SOCIAL SECURITY NUMBER:_____-_____-_____

INSURANCE (please read)

The presence of Insurance is NOT A GUARANTY OF PAYMENT.

Please present any and all insurance information/cards BEFORE services are rendered. It is the responsibility of the patient and/or parent/guardian to know and understand the policies and benefits of their insurance. You are responsible for the payment of all of the services and/or materials rendered. We will help you anyway we can to claim your benefits. Most insurances will not allow us to back-date a claim. Therefore, you must disclose all insurance coverage prior to services being rendered so that we can check/authorize benefits.

NOTE: There are 2 basic kinds of insurance coverage

1. **Eye health (Medical)**
2. **Vision (Routine Vision-no medical condition)**

Medical insurances generally cover anything to do with the health of your eyes, ie diabetes, glaucoma, cataracts, eye infections, eye injuries etc. They do NOT cover service for routine eye exams, refractions, glasses, contact lenses etc.
Vision Insurances do not cover eye health exams. They only cover routine vision exams(no medical problems), glasses and contact lenses.
Medical insurances and Vision insurances DO NOT coordinate benefits with each other. Therefore, If we treat you for a medical condition during your visit, we WILL file your Medical insurance and you will be responsible for items not covered by your plan. Typically, insurance DO NOT COVER all charges. You will be expected to pay for non covered items, overages, and co-pays as services are rendered

PRIMARY MEDICAL INSURANCE:_____ POLICY NO. _____

Insured's Name if different from patient:_____ DOB:_____

OTHER MEDICAL INSURANCE:_____POLICY NO. _____

PRIMARY VISION INSURANCE: _____POLICY NO._____

Insured's Name if different from patient:_____DOB:_____

OTHER VISION INSURANCE:_____

INFORMATION RELEASE AND INSURANCE ASSIGNMENT

I understand that I am personally responsible for payment of services and materials not covered by my medical/vision insurance and agree to do so. I authorize Vision Plus Eyecare and it's doctors to release any medical/vision information necessary to process my medical/vision insurance claims and/or to aid in further care of my eye health or vision status. I authorize and request payment of medical/vision benefits directly to Vision Plus Eyecare. I agree that my signature on this authorization form will cover all medical/vision services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in lieu of the original.

PAYMENT OF SERVICES

OUR PAYMENT POLICY:

- Fees for services are due at the time the services are rendered. This includes Co-pays, deductibles, and non-covered services.
- At least ½ the cost of ophthalmic purchases (glasses or contacts) is required before orders can be placed.
- Balance of account is due upon dispensing of materials.
- Orders for materials can not be canceled once they have been placed.
- We accept cash, checks, Visa, Mastercard, Discover, Amex, and Care Credit.
- We will NOT hold checks.
- There is a $45 service fee for returned checks.

I have read, understand and agree to the terms of the insurance, release of information, and payment policy.

Signature:_____
Date:_____

HOW DO YOU PLAN TO PAY TODAY?

Cash_____ Check_____ Credit/Debit _____ Care Credit_____

Drivers License Number:_____

*Any arrangements outside of the above payment policy must be approved prior to your appointment.