

WELCOME TO

SPRING HILL EYECARE PLLC



See What You've Been Missing!

1. ABOUT YOU

Today's Date: ___ / ___ / ___

Patient Name: _____
LAST FIRST MI

Preferred Name: _____ Male Female

Title: Mr. Mrs. Ms. Miss Dr. Rev. Other: _____

Birthdate: ___ / ___ / ___ SS# ___ - ___ - ___

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: (____) _____ - _____

Cell Phone #: (____) _____ - _____

E-mail Address: _____

Employer Name: _____

Occupation: _____

Status: Minor Single Married Divorced Separated Widowed

Spouse's Name: _____

Responsible Party If patient is a minor:

Name: _____ Birthdate: ___ / ___ / ___

SS#: _____

Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Note: The parent/guardian/adult accompanying a minor child is responsible for full payment on the day services are provided, if not covered by insurance.

4. IN CASE OF EMERGENCY

Whom should we contact? _____

Relation: _____

Phone #: (____) _____ - _____

Name of Primary Care Doctor: _____

Primary Care Doctor's Office: _____

Preferred Pharmacy: _____

2. VISION INSURANCE INFO

VISION Insurance

Insurance Company: _____

Subscriber/Member ID# _____

Group #: _____

Subscriber's Name: _____

Subscriber's SS# _____

Subscriber Birthdate: ___ / ___ / ___

Relation to Patient: _____

Subscriber's Employer: _____

3. MEDICAL INSURANCE INFO

Primary MEDICAL Insurance

Insurance Company: _____

Subscriber/Member ID# _____

Group #: _____

Subscriber's Name: _____

Subscriber's SS# _____

Subscriber Birthdate: ___ / ___ / ___

Relation to Patient: _____

Subscriber's Employer: _____

Supplemental MEDICAL Insurance

Insurance Company: _____

Subscriber/Member ID# _____

Group #: _____

Subscriber's Name: _____

Subscriber's SS# _____

Subscriber Birthdate: ___ / ___ / ___

Relation to Patient: _____

Subscriber's Employer: _____

6. CONSENT

By signing this form, I consent to treatment for myself. I give permission for the doctor(s) to examine, diagnose and initiate treatment as deemed appropriate.

Patient's Signature: _____ Date: ___ / ___ / ___

Optomap Retinal Imaging

We pride ourselves on providing our patients with the best possible standard of care. Because of this, we perform the Optomap Retinal Exam on all patients. The Optomap allows our doctors to capture an image of the back of your eye where potential vision threatening diseases can be found.

When reviewed, the scan becomes a permanent part of your medical file, enabling the doctor to make important comparisons should potential vision threatening conditions show themselves at a future examination.

The doctor prescribes the Optomap Retinal Exam each year for all patients.

As part of your pre-test work up, we will capture the Optomap images for review. There is a \$35 fee for the Optomap that is not covered by your vision plan. If the doctor deems a medical diagnosis, the Optomap may be billed to your medical insurance, which will be subject to copay/deductible/coinsurance. Your medical insurance may consider it a non-covered service, in which case you will still be responsible for payment.

I have read and understand this document

Printed Name of Patient: _____

Signature of Patient or Guardian: _____

Date: _____

ACKNOWLEDGEMENT OF PRIVACY POLICY AND PRACTICES

I understand that in an attempt to protect the privacy of my identifiable health information, Spring Hill Eyecare, PLLC has established a *Privacy Policy* and guidelines for *Privacy Practices* within their office. This information details the use and/or disclosure of information contained in my personal medical/optometric records kept for the purpose of diagnosis, treatment, payment and health care operations. In accordance with HIPAA Regulations, a copy of the *Notice of Privacy Practices* of Spring Hill Eyecare, PLLC has been made available to me while in the office today. Should I choose to have a personal copy, one will be given to me at no charge.

I have read, understand, and acknowledge the *Notice of Privacy Practices* of Spring Hill Eyecare, PLLC.

I have elected not to read the *Notice of Privacy Practices* of Spring Hill Eyecare, PLLC.

I understand that the Practice may wish to contact me by phone, email, or text for purposes related to my treatment such as to remind me of appointments, leave messages, or to discuss financial/billing business, or to indicate other necessary contacts.

Patient name _____

Signature (or patient's representative) _____ Date _____

The following people may have access to my personal health information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

FINANCIAL POLICY

Thank you for choosing our office as your eye care provider. The following is a statement of our financial policy. Please read carefully prior to any services performed.

INSURED PATIENTS:

Your insurance policy is a contract between you and your insurance company. All insurance plans must be brought to our attention **prior** to receiving services/products, and we must have a copy of the most current insurance card. We will submit charges to your insurance company if we are a participating provider and if you have given us all the required information. You must notify us immediately of any change in your insurance coverage. Our staff will attempt to verify insurance coverage prior to your appointment. Although we provide this research as a courtesy, **it is the patient's responsibility to check with their insurance plan regarding their coverage and in network status**. If the benefits cannot be verified, the full charge of the visit must be paid before leaving the office. Benefits are not determined by our office. It is the responsibility of the patient to know their benefits. **We will not bill insurance plans after the date of service. If incorrect or expired insurance information is provided, the patient will assume full financial responsibility.** All patients are responsible to confirm coordination of benefits with their medical plans. We will not refile claims if they are denied due to COB. Patient will be responsible for payment. Medicare patients are responsible to alert Medicare of all secondary and supplement plans. Spring Hill Eyecare will not file Medicare crossover claims.

Please be aware that some, and perhaps all, of the services provided may be considered "non-covered services" according to your policy or your eligibility. You will still be responsible for payment of these services. Additional charges may not be discovered until we receive the explanation of benefits from your insurance company, and we may be required to collect additional charges. Our office will not enter into a dispute with an insurance company, although we will work with the insurance company to sort out any confusions or questions that might arise. We cooperate fully with the regulations and requests of the insurance companies. It will be, however, the responsibility of the patient to handle with the insurance company any type of dispute over payment by the company. If a patient's insurance company has not made payment to our office within 90 days, we will require the patient to pay the balance due and then seek reimbursement from the insurance company. ***If we are a non-participating provider with your insurance company, you will be responsible for charges at the time of service.***

NON-INSURED PATIENTS:

Non-insured patients are responsible for charges in full at the time of service.

AUTHORIZATION AND REFERRALS:

If the patient's insurance plan requires a referral, it is the patient's responsibility to obtain the referral. If the referral or authorization is not received, the patient is responsible for all professional fees and materials. You will be responsible for payment of any copays, deductibles, co-insurance, or non-covered services.

MINOR PATIENT (UNDER 18 YEARS):

All minors under 18 years old must be accompanied by their parent or legal guardian. The parent/guardian accompanying the minor child is responsible for full payment of services/products that day.

PRODUCTS: When purchasing contact lenses or glasses, we require at least a 50% deposit with the balance due upon delivery of those materials. If products are not picked up within 30 days, products will be returned, the deposit will not be refunded, and any benefits will be forfeited. All materials

directly shipped to you must be paid in advance. Spectacle prescription and contact lens changes must be requested within 30 days of dispensing. Eyewear and contact lenses are special order items and once ordered cannot be cancelled. There are NO RETURNS/REFUNDS for prescription or non-prescription spectacles, non-prescription sunglasses, contacts lenses or any other custom-made products. ALL SALES ARE FINAL.

PAYMENT OPTIONS:

We accept Visa, Master Card, Discover, American Express, Care Credit, cash, and checks. Please note: There will be a \$30 charge for any checks returned to our office – plus any magistrate fees if further collection proceedings are deemed necessary.

COLLECTION BALANCES:

If you have a previous balance or are presently in collection, it will be **required that you pay your previous balance prior to being seen again or ordering any materials**. A late fee of 2% per month will be added to all balances over 30 days. Accounts past 90 days may be sent to collections. Patient agrees to pay all expenses of collection including reasonable attorney fees.

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits.

I request that payment of the authorized Medicare or other insurance benefits be made on my behalf to Spring Hill Eyecare, PLLC and/or Dr. Robert R. Szeliga and Associates for services and/or materials furnished to me by Spring Hill Eyecare, PLLC and/or Dr. Robert R. Szeliga and Associates. I authorize any holder of medical information about me to release to the Centers of Medicare and Medicaid Services and its agents any information needed to determine those 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 I have "other health insurance" as indicated on item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In insurance and/or Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge; however, the patient is responsible for the deductible, copay, and coinsurance (both based upon the charge determination of the Medicare carrier) and any non-covered services.

SIGNATURE FOR ABOVE POLICIES

I HAVE READ AND UNDERSTAND ALL AREAS ABOVE. MY SIGNATURE BELOW INDICATES THAT I UNDERSTAND AND AGREE TO THESE POLICIES.

X

SIGNATURE of Patient or Parent/Guardian

PRINTED NAME of Patient

Date