Eye Definition
VISION | HEALTH | STYLE

New Patient Information

Todays Date_____

Name:_____ Mr., Mrs., Ms., Miss, Rev, Dr. Sex: M/F
First Middle Last

Patients's Social Security #____-____-____ **Date of Birth**___-___-____ **Status:** Single / Married / Dating / Widow

Mailing address:_____
Street Apt# PO Box City State Zip Code

Home Phone:_____ **Cell Phone:**_____**Email:**_____

Patient Employer:_____ **Occupation:**_____**Phone:**_____

Employer address:_____
Street City State Zip Code

Guarantor_____ _____ _____
(Person responsible for bill if other than patient) Phone Relationship to Patient

Guarantor's Employer:_____
Company Name Street City State Zip Code

In Case of emergency Contact or Secondary contact (person not living with patient)

Name:_____Relationship:_____Phone:_____

Primary Care Physician:_____Phone:_____

Medical Insurance Information *(If you need Prior Authorization from your family physician, please obtain prior to your visit)*

Primary Insurance Carrier_____**Policy#**_____**Group#**_____

Policy Holder's Name:_____Social Security #_____-_____-_____Date of Birth_____

Policy Holder's Employer or Retiree's former employer:_____

Vision Insurance Carrier_____**Policy#**_____**Group#**_____

Policy Holder's Name:_____Social Security #_____-_____-_____Date of Birth_____

Policy Holder's Employer or Retiree's former employer:_____

Do you have a Flexible Spending account or Health Savings Account: YES / NO

How did you hear about our Office? Is there someone we may thank?_____

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Billing of Insurances

Most people have vision insurance and medical insurance. They are very different in terms of the services they cover and it's important for our patients to understand those differences. Vision coverage (VSP, Eyemed, Spectera, etc.) is mainly designed to determine a prescription for glasses and is not equipped to deal with complex medical conditions and/or diagnosis. It does allow for screening of conditions, but once they are determined, then medical insurance is filed on those services. When a medical condition is present (such as diabetes, cataracts, dry eye, floaters, etc.) it is necessary to file the visit with your major medical carrier (BCBS, Aetna, UHC, Cigna, etc.) and the co-pays, deductible, and co-insurance for that insurance will apply as well as the non-covered service. Insurance carriers set these rules and our office is obligated to follow them. In most cases, there is no way to know prior to the examination which type of insurance our office will be able to file for you. We make every effort to be on every major carrier for your convenience and we will file those claims for you. In the event that we do not take your insurance we will provide you with an itemized receipt so that you may file with your carrier for reimbursement. If you have any questions, please let us know.

I understand the paragraph above and authorize Eye Definition to file my insurance by the above guidelines.

Patient/Parent or Guardian Signature:_____**Date**_____

It is the policy of Eye Definition to require **PAYMENT AT TIME THE SERVICES ARE PROVIDED.** By signing below I am stating that I understand this policy. I understand that in the event of a returned product, Eye Definition may charge a restocking fee that will vary based on the company's expenses/costs. If my account balance remains unpaid after receiving a 60 day statement, I will be responsible for that balance plus an additional 1.5% monthly interest on the amount due. However, if the small balance on my account is under $25 I should only expect to receive a statement every 6 months. Remember that insurance is a form of reimbursement made on behalf of the patient to the doctor for service rendered and **NOT A SUBSTITUTE** for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to know what your insurance pays and to pay any deductible amount, co-insurance or any other balance not paid for by your insurance.**

I herby instruct and direct Insurance Company to pay by check made out and mailed to:
Eye Definition, 405 N. Canton Center, Canton MI 48187 or if my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows: Eye Definition, 405 N. Canton Center, Canton MI 48187. For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services reentered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. Any products returned to Eye Definition may be assessed a restocking fee. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of my patients records, as per HIPPA policy.
I hereby assign all medical and or surgical benefits, to include major-medical benefice to which I am entitled including Medicare, private insurance and other health plans to **Eye Definition.**
I also authorize the Doctor to deposit checks received on Patients's account when made out to the Patient.
This assignment will remain in effect until revoked by me in writing. A photo copy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I am responsible for all services not covered by insurance plans. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient/Parent or Guardian Signature:_____**Date**_____

I have read the ***NOTICE OF PRIVACY PRACTICES FORM*** that is attached to the clipboard, or was presented to me at the time of my appointment. I understand and accept the policies as noted in said forms.

Signature of Patient / Parent / Personal Representative_____**Date**_____