EYECARE ASSOCIATES *of* EAST TEXAS

WELCOME…

To EyeCare Associates of East Texas! We are honored that you have chosen EyeCare Associates to meet your eye care needs! We have enclosed an appointment card with the date and time of this appointment for your convenience. A map to our office in also enclosed.

Please complete your enclosed **Registration** and **Patient History** forms and bring them with you to your appointment. It is important to list your <u>local and mail-in pharmacy</u> information at the bottom of your Registration form. Also, both sides of the Patient History form need to be completed, as we need to know about your current and previous medical conditions to provide you with quality and comprehensive care.

Your examination may require the dilation of your eyes and this could slightly impair your vision for a few hours. We recommend you have someone prepared to drive for you after your appointment.

If you have been referred to our practice for an evaluation or second opinion, a thorough letter of our findings will be sent to your doctor after your visit. Therefore, please include your <u>Referring Doctor and Primary Care Physician's</u> name on your Registration Form.

If you have medical insurance and/or a vision plan, please bring your insurance card(s) and a current photo ID (to verify identity) to your visit. **<u>In preparation for the appointment, please check with your insurance company in advance to verify that our physicians participate in your medical insurance and/or vision plan</u>**. It is your responsibility to know this ahead of time and to pay any co-pays and/or deductibles. Our office will file the visit to your insurance company, but if you are uninsured, you are required to pay in full at check out. **Also, you may be responsible for a $35.00 refraction fee at time of service.** Many medical insurance companies (Medicare included) do not cover refraction or routine vision services.

If you participate in a PPO or HMO insurance plan **<u>requiring a referral or authorization number</u>**, you will need to call your Primary Care Physician to obtain this number before your appointment. **We cannot see you without this number.**

Please know your coverage beforehand and review our enclosed *<u>Insurance Information</u>* handout for additional details on insurance coverage. Do not hesitate to call if you have any questions regarding our financial policy.

If you must cancel and/or re-schedule this appointment, please notify our office at least 24 hours in advance. We look forward to seeing you at your visit!

Sincerely,

The Physicians & Staff of EyeCare Associates

Enclosures

EYECARE ASSOCIATES of EAST TEXAS

REGISTRATION FORM

PATIENT INFORMATION

Last Name ____________________________ First Name ________________________ M.I. _____ Nickname ____________________________

Marital Status: Single___________ Married___________ Divorced___________ Widowed___________ Legally Separated ___________

Patient D.L.# __________________________ State _____ Social Security# ________________________________ Date of Birth ____________

Sex: Male / Female (circle one) Preferred Language: English______ Spanish______ Other________________________________

Ethnicity: Hispanic/Latino_________ Not Hispanic/Latino_________

Race: Asian_____ White_____ American Indian or Alaska Native_____ Black or African American_____ Other_____

Emergency Contact: (relative, neighbor, or friend) _________________________________ Phone# _____________________________________

Spouse Full Name:____ Phone# _____________________________________

Caretaker Full Name:____ Phone# _____________________________________

Patient Home Phone# _________________________ Work Phone#_________________________ Cell Phone# ________________________

Preferred Contact By: Home#_____ Work#_____ Cell#_____ Is it okay to leave a detailed message? Yes_____ No_____

Email Address ____

Mailing Address ____ City _________________________________ State _____ Zip __________

Employer Name ____ Not Employed____________ Retired ____________

PERSON RESPONSIBLE FOR THE BILL ***(ONLY APPLICABLE IF OTHER THAN THE PATIENT)***

Last Name ____________________________ First Name ________________________ M.I. _____ Relationship to Patient _________________

Social Security# ____ Date of Birth__________________________

Mailing Address ____ City _________________________________ State _____ Zip __________

Home Phone#_______________________________ Work Phone#___________________________ Cell Phone# _________________________

INSURANCE INFORMATION ***(PLEASE LIST POLICY HOLDER IF OTHER THAN THE PATIENT)***

Name ____ Date of Birth__________________________

ADDITIONAL INFORMATION

Local Pharmacy ____ Address____

Mail-In Pharmacy ____ Address____

Referring Physician ____ City ____

Primary Care Physician ____ City ____

How did you hear about EyeCare Associates?____

- OVER -

YOUR ELECTRONIC SIGNATURE IS REQUIRED TO CONFIRM YOUR UNDERSTANDING OF SPECIFIC EYECARE ASSOCIATES OF EAST TEXAS, PLLC POLICIES WHICH ARE OUTLINED BELOW.

CONSENT TO TREATMENT: I voluntarily consent to receive medical and health care services provided by EyeCare Associates of East Texas physicians, employees and such associates, assistants, and other health care providers as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations and treatment. I acknowledge that no warranty of guarantee has been made to me as to result or cure.
I understand that this consent to treatment will be valid and remain in effect as long as I attend EyeCare Associates of East Texas clinics, unless revoked by me in writing.

RELEASE OF INFORMATION: I understand my signature authorizes release of confidential medical information necessary to pay the claim to Medicare or other health insurer.
I understand that I may revoke this authorization for the release of information at any time, by providing written notice to EyeCare Associates of East Texas, except to the extent that action has been taken in reliance on it.

RELEASE OF LIABILITY: I release and agree to hold harmless EyeCare Associates of East Texas and its agents, representatives, and employees from any and all liability associated with the release of confidential patient information in accordance with this authorization. I understand EyeCare Associates of East Texas cannot be responsible for use or re-disclosure of information by third parties.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign my right, title and interest in all insurance, Medicare/Medicaid, or other third party payor benefits for medical or health care services payable to me, payable to the providers of EyeCare Associates of East Texas. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third party payor, up to the total amount of my medical and health care charges to the providers of EyeCare Associates of East Texas. I certify that the information I have provided in connection with any application for payment by third party payors, including Medicare/Medicaid, is correct.
I agree to pay all charges for medical and health care services not covered by or which exceed the estimated amount to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third party payor and agree to make payment as requested by EyeCare Associates of East Texas.

REFRACTION: I understand that refraction (measurement of eyes for glasses / contacts) is a non-covered service. I accept full financial responsibility for the cost of this service. The co-pay is separate from and not included in the refraction fee.

INSURANCE INFORMATION: At EyeCare Associates of East Texas we accept most major insurances, and assist our patients by filing claims to their primary and secondary insurances. All patients are required to pay any co-pays, deductibles, and non-covered items at time of service. Our goal is to refund an account credit balance as soon as possible.

INSURANCE COVERAGE - ROUTINE vs MEDICAL EYE EXAM: We strive to know what your insurance will cover, but also encourage our patients to become proactive in understanding their insurance coverage as well. One important concept to understand is that **Medical Insurance** covers medical problems, whereas, **Vision Plans** only cover routine eye care and hardware. Most frequently, you will have separate policies and cards for medical and vision coverage. Medical insurances usually do not cover routine vision services; however, some include limited routine vision benefits. Please familiarize yourself with your coverage prior to your visit. The reason for the visit, diagnosis of condition, and plan of treatment determine whether a visit is routine or medical from an insurance standpoint. Whether routine or medical, you can expect to receive a thorough exam and quality treatment at EyeCare Associates of East Texas. Here, we strive to help the patient in all areas of the *EyeCare* experience.

MEDICAL INSURANCE: In addition to commercial insurances, we work closely with the following government agencies: Texas Rehab, State Commission of the Blind, Texas Diabetic Council, Smith County Indigent, Medicaid, and Medicare (most Medicare Advantage/ Replacement Plans).

HMO MEMBERS: For most HMO insurance plans, you are responsible for obtaining a valid referral/authorization on your **initial** visit. After the initial visit, our staff can assist you with referrals/authorizations for future visits.

PRE-CERTIFICATION: Our staff will take care of all pre-certification requirements for certain surgeries or procedures.

VISION PLANS: For patients with routine vision coverage plans, please check before your visit to see if our doctors are on your plan.

EYECARE ASSOCIATES OF EAST TEXAS NOTICE OF PRIVATE PRACTICES: I acknowledge that a copy will be made available upon my request.

______________________________ ______________________________

Witness Signature Date | Patient / Agent / Guardian Signature Date