Plymouth Family Eyecare

Patient Name _____ DOB _____ Date _____

Contact information (please list order of preferred contact) ☐ E-mail address _____

☐ Home _____ ☐ Cell _____ Text msging Y or N? ☐ Work _____

Primary Insurance Policy Holder Name _____ DOB _____

Place of employment _____ SS# _____

Relationship to patient: _____ Self _____ Spouse _____ Child Other _____

Signature on file: I authorize Plymouth Family Eyecare to release to my insurance companies, the Social Security Administration, Health Care Financing, or agent of Medicare or of my supplemental insurance any information needed to determine my insurance coverage, Medicare or supplemental insurance benefits. I further authorize all insurance companies or agents of Medicare to release to doctors any information needed to resubmit denied or incorrectly paid claims. I authorize Plymouth Family Eyecare to file claims with all co-insurance and further authorize and direct my insurance benefits to be paid directly to Plymouth Family Eyecare I request that payment of authorized Medigap benefits (Item 9 of the CMS 1500 form) be made either to me or on my behalf to Plymouth Family Eyecare for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to (name of Medigap insurer) any information needed to determine these benefits or the benefits payable for related services. **Initial** _____

Non Covered Services: I understand that Plymouth Family Eyecare contracts with health care service plans (i.e., VSP, EyeMed) relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Plymouth Family Eyecare to obtain necessary health care service plan authorizations. **Initial** _____

Privacy Practices Policy Notification: I acknowledge that I received a copy of Plymouth Family Eyecare's Notice of Privacy Practices which describes how we protect your health information and what rights you have regarding it. **Initial** _____

Is there anyone you would want us to be able to share your information with:_____

Notice of Payment Policy: All professional fees, including exam and any additional testing recommended by the doctor, are due and payable the day they are provided. If glasses or contact lenses are included in your fees, 50% is required when ordering and the balance is due at dispensing.

If your fees are covered by a vision plan for which we are participating providers, or by Medicare or Medicaid, any applicable deductibles, co-payments and non-covered services and/or materials are due and payable on the date of your examination.

A prompt payment agreement is available to patients whose examination fees are not covered by a vision plan or who do not have any type of vision coverage. By signing a prompt payment agreement the patient agrees to the terms of this contract which provide a reduction in our usual and customary examination fee. This agreed upon amount, as determined by the contract, is payable at the time of your initial visit. **Initial** _____

I understand that any fees incurred are my responsibility, unless otherwise prohibited by law, regardless of any insurance benefits, and that they are to be paid as stated in the above payment policy. Any collections and/or legal fees are also my responsibility. **Initial** _____

Payment will be made by:

☐ Self (Ask office receptionist for Prompt Payment Agreement/Contract)

☐ Insurance (name) _____

Patient's Name _____

Patient's Signature or Authorized Party _____ Date _____