NORTH POLE EYECARE

PATIENT INFORMATION

Last Name: _____ First Name: _____Middle Initial: ____ Sex: _____
Mailing
Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Email: _____

Date of Birth: _____ Social Security No.: _____ Marital Status: _____

Employer: _____ Family Physician: _____ Doctor Phone: _____

RESPONSIBLE PARTY (if patient is under 18 years of age):

Last Name: _____First Name: _____ Middle Initial: ____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Social Security No.: _____ Relation: _____

EMERGENCY CONTACT INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: ____ Relation: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

INSURANCE COVERAGE #1: **Medical Plan** **Vision Plan**

Insurance Name: _____Member ID#: _____Employer: _____

Insured Name: _____ Date of Birth: _____ Relation: _____ SSN: _____

INSURANCE COVERAGE #2: **Medical Plan** **Vision Plan**

Insurance Name: _____Member ID#: _____Employer: _____

Insured Name: _____ Date of Birth: _____ Relation: _____ SSN: _____

INSURANCE COVERAGE #3: **Medical Plan** **Vision Plan**

Insurance Name: _____Member ID#: _____Employer: _____

Insured Name: _____ Date of Birth: _____ Relation: _____ SSN: _____

INSURANCE COVERAGE #4: **Medical Plan** **Vision Plan**

Insurance Name: _____Member ID#: _____Employer: _____

Insured Name: _____ Date of Birth: _____ Relation: _____ SSN: _____

NORTH POLE EYECARE

We often have patients that have both vision insurance (for example, VSP) and medical insurance (for example, Blue Cross, Aetna, or Medicare). They are quite different in terms of the services they provide, and it is important for our patients to understand these differences.

Vision insurance is designed to cover determining a prescription for glasses, to help pay for glasses or contact lenses, and to cover a yearly routine evaluation of the health of the eyes in a healthy patient that has no problems or symptoms. It is not able to deal with and does not usually cover medical conditions, injuries, and/or treatments.

Medical insurance is designed to cover you when you have a medical problem, including one that affects your eyes. Medical insurance does not cover routine services or examinations for glasses, or routine vision problems such as nearsightedness, farsightedness, and astigmatism. Those are only covered by your vision insurance.

When a medical diagnosis or medical condition is present that affects your eyes, such as high blood pressure, high cholesterol, or diabetes, to name just a few examples, or you have an eye disease or eye problem such as an infection (pink eye), dry eyes, allergy, or cataracts, again, just to name a few, we must file the claim with your **medical insurance**, and the co-pays and deductibles for that insurance will apply. Your vision plan does not cover these kinds of problems. Our office does not make these rules, the insurance companies themselves make them, and we must comply with them.

There is often no way to know prior to your examination which type of insurance will be the right one to file your claim with. We make every effort to join as many insurance panels, both medical and vision, as we can for your convenience. If we are on your insurance company's panel, we will file those claims for you. If we do not accept your medical or vision insurance, we will provide you with an itemized receipt so that you may file a claim for reimbursement with your insurance company yourself. If you have any questions, please let us know.

PLEASE READ AND INITIAL EACH STATEMENT BELOW:

_____ I understand that it is my responsibility to verify that the provider is on my plan.

_____ I understand that if my insurance company does not cover any part of my visit, I am responsible for payment. Please remember your insurance contract is between you and the insurance carrier. It is considered a method of reimbursing the clinic for patient care services and is 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 pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

_____ Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or cell phone at which a may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or cell phone from the Practice.

_____ Payment for services is expected to be paid at the end of each visit unless our office participates in your insurance or other arrangements have been made prior to your visit.

_____ I understand that there is a return check fee of $30. Return check fees are assessed on any bad/returned check including ACH payment plans. $30 will be assessed on each occurrence. Return check fees may be withdrawn automatically from your financial institution as soon as funds are available.

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to be paid to North Pole Eyecare. I understand that this serves as my signature on file for all insurance and records releases needed for billing/collection purposes.

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

I have Reviewed All Information on this form and updated as needed:

Initials:										
Date:										