Eyes on 45th

Patient Financial Information Sheet

I understand that payment in full is due at time of service unless other arrangements have been made.

Name of Patient: _____ **DOB**_____

Name of Policy Holder: _____ **DOB of Policy Holder:** _____

Social Security Number of Policy Holder: _____ _____ _____

If No Insurance Card is Available please supply the Insurance Carrier and ID #
Name of Insurance Carrier: _____

ID#:_____ **Policy #:**_____

Insurance Card Copied: _____ Yes _____ No _____ No Card

Authorization and Release:

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

I authorize the release of any information including the diagnosis and the records of any treatment or examinations rendered to me or my child to: _____

These authorizations are valid for one year

Patient Billing Agreement:

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents including all co-pays and deductibles associated with my insurance plan.

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

Refraction Policy:

The Refraction is the process of determining your eye's refractive error and it is our Optometrists' opinion that the **refraction** is an essential part of an eye exam. **Refraction** may be necessary for diagnostic purposes and to establish the need for **OR** to update your corrective glasses and/or contact lenses prescription. Refraction is **NOT** a covered service by Medicare or most other medical insurances and the $30 fee may be your responsibility.

_____ _____
Signature of patient or parent if minor Date

HIPAA Privacy Practice acknowledgement

I understand that, in accordance with HIPAA, my information will not be shared outside the Eyes on 45th office, except as I request for healthcare or payment purposes.
I understand a full notice of privacy practices is available for review upon my request*.

Signature:_____ **Date:**_____

☐ Patient Declined to sign _____

*Privacy Practice Notice Available at the Reception Desk