HORIZON EYE SPECIALISTS & LASIK CENTER

ROBERT R. McCULLOCH, M.D. • DANIEL B. FELLER, M.D.
HARMOHINA BAGGA, M.D. • JONATHAN J. LEVIN, M.D.
SHIRLEY J. LAMBERT, O.D. • KACI KRAMER OLDROYD, O.D.
JEFFREY L. GIRARDIN, O.D. • DAVID T. ROCKWELL, O.D.

Account #

Patient's **LEGAL** Name(first, middle, last)	Social Security #	Date of Birth	Gender M ☐ F ☐	Marital Status S ☐ M☐ W☐ D☐
Street Address Permanent ☐ Temporary ☐ Apt #	City and State	Zip Code	Home # w/ area code	
Email address	Cell phone #	Occupation		
Patient's Employer	Race	Ethnicity	Language	

Referred by:	Family Physician & phone #	Referring Optometrist & Phone #

Whom should we contact in case of emergency? (Relative or friend not living with you)

Name	Relationship	Home # with area code
Street Address	City, State and Zip Code	Cell # with area code

Insurance Information Do you have health Insurance? Yes ☐ No ☐

Primary Insurance Company	Address	City, State and Zip Code	Phone # with area code
Policy or Identification #	Group #	Name of Insured	Relationship to insured
SS # of insured (if not patient)	Date of Birth (if not patient)	Home # w/ area code	Occupation (How Long?)
Employer of Insured's policy – if through Employer- (name and address)			
Secondary Insurance Company	Address	City, State and Zip Code	Phone # with area code
Policy or Identification #	Group #	Name of Insured	Relationship to insured

Consent for treatment, release of information, financial agreement & assignment of benefits

I or my representative, recognizing the need for care, consent to all and any services as ordered by my physician, including, but not limited to, laboratory tests, medical or surgical treatment examination, and other services rendered under the specific instructions of my physician. Although this office may assist me in filing any insurance claims, I understand that I am fully responsible for the balance and agree that payment will not be delayed because of any pending insurance claim. I authorize all insurance benefits, unless previously paid by myself, to be paid directly to this physician and I also authorize the provider to release any information needed for payment of claims.

Patient Signature:_____ **Date:**_____

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FINANCIAL POLICIES

PATIENTS OF CONTRACTED MANAGED CARE PLANS:

If our office is contracted with your health care plan, we still submit your claim to your carrier. You are expected to pay your co-pay at the time of service, per your contractual agreement with your insurance carrier. **Secure Horizons/AARP Medicare Complete** policy holders are required to pay a co-pay at every visit including post-operative visits.

You are responsible for all services provided by our office which are not covered by your insurance. Please contact your insurance company in advance to verify coverage for benefits such as refractions, contact lens exams and routine eye care and any deductibles that may apply.

PATIENTS WITH PRIVATE HEALTH INSURANCE PLANS:

You are responsible for payment in full at the time of service. We provide you with a paid receipt for you to submit to your insurance for reimbursement. As a courtesy, and upon request, we will file your insurance claims providing **payment is made in full at the time of service.** In this case, the insurance company will reimburse you directly for your paid claim. Refraction/check for glasses is not a covered benefit under most insurances. The refraction charge is **$55.00;** you are responsible for payment of this at the time of service.

PATIENTS WITH NO INSURANCE BENEFITS:

You are responsible for payment in full at the time of service.

ALL PATIENTS OF OUR PRACTICE:

Please bring your insurance cards with you and keep our office informed of any changes in your insurance, address, telephone or employment. For your convenience we accept Debit Cards, Mastercard, Visa, Discover, American Express, Checks and Cash.

Insurance issues, requirements and coverage are ever changing. We are making every effort to be in compliance and to eliminate payment denials before they occur. Your insurance plan *may or may not* cover routine eye services.

We are legally obligated to assign procedure codes based on the services provided to you, whether it is routine eye exam or a visit to take care of problems or both. We cannot change the coding later to cause the insurance company to pay for a non-covered service.

Based on the kind of coverage you have, some or all of the cost may have to be billed to you.

DELINQUENT ACCOUNTS:

Accounts greater than 60 days past due are subject to collection and associated collection fees.

Misc Forms:

Requests for form completion ie. FMLA, drivers license, disability forms etc, are subject to a $15.00 fee.

Return Check fee is $25.00

ACCEPTANCE:

I have read and understand the financial policy and agree to abide by the terms of this policy.

_____ _____

Patient Signature Date