Today's Date: _____

Patient Information:

Name: _____Date Of Birth: _____Sex: ____

Address: _____

City: _____State: _____ Zip Code: _____

Home Phone #: _____Cell #: _____Work #: _____

Email Address: _____

Employer: _____ Occupation: _____

In Case Of Emergency Contact: _____ Phone #: _____

Insurance Holder/Guarantor's Information:

Name: _____ Date of Birth: _____

Phone #: _____ Relationship: _____

Referral/Authorizations from Your Primary Care Doctor/Insurance: If your insurance company requires that you obtain a referral/authorization number it is the patients responsibility to get this number and give the information to Advanced Eye Care. If you do not obtain this authorization your insurance may not pay for your exam. It is the patient's responsibility to make sure that the authorization number is current. **Initial:** _____

Medicare And Medicare Combined Plans: Medicare and Medicare Combined plans will not cover the **$40.00** refraction fee. A refraction is the part of the exam that determines what your new glasses/contact lens prescription will be. You will be responsible to pay this fee on your date of service. **Initial:** _____

Insurance Information:

Name Of Insurance: _____

Billing Address: _____

Policy/ID #: _____ Group #: _____

Office Financial Policy

We request all office charges or co-pays to be paid at the time of service by cash, check, or credit card. An "Attending Physicians Statement" will be sent to your insurance company to assist you in obtaining reimbursement for covered expenses. Collection from your insurance is your responsibility. You will be responsible for the payment of all charges and pay for all costs of collection and legal fees. If Advanced Eye Care does not receive your monthly payment your account will be charged a $4.78 monthly billing charge.

I authorize the doctors of Advanced Eye Care to furnish all pertinent information and medical records concerning my diagnosis to my designated insurance carrier(s). I also authorize benefits under my insurance claim to be paid directly to the doctors of Advanced Eye Care.

I have read, understand, and agree to the provision of the Advanced Eye Care Financial Policy.

Signature: _____Date: _____

Medicare Patients

Physician Notice

Medicare will only pay for services that determines to be reasonable and necessary under section .1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is not reasonable and necessary under Medicare program standards Medicare will deny or reduce payment for that service. Currently Medicare is denying payment for Refractions (92015), the determination of glasses or a contact lens prescription as a non-covered service.

Beneficiary Notice

I request that payment of authorized Medicare benefits be made to me or on my behalf to Advanced Eye Care for services provided to me by my physician. I authorize any holder of medical information about me and any information needed to determine these benefits or the benefits payable to related services be released to the Health Care Financing Administration and its agents.

Signature: _____ Date: _____