CORNING EYE CARE

400 Solano St.
Corning, CA 96021
Ph 530-824-2166

PATIENT DEMOGRAPHICS

Patient Name: _____ Sex: M F

Home Phone: (_____) _____ Cell Phone (_____) _____

Mailing Address: _____ City: _____ State/ Zip: _____

Soc. Sec#: _____ DOB: _____Status: (circle) S M D W Minor

(Needed for Medicare, Medi-cal, patients w/vision insurance or students covered under parents insurance)

E-Mail Address: _____

Responsible Party: _____ Relationship to Patient: _____

Employed by: _____ Employer Phone: _____

Address: _____ City/State/Zip: _____

Family Physician: _____ Family Physician Phone: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

Vision Plan Coverage Information: (CIRCLE ONE) ☐ VSP ☐ MES ☐ EYE MED ☐ Principal ☐ NVIH

Policy Holder: _____ **DOB:** ____/____/_____ **SS#:**_____

Medical Insurance Information:

Primary: _____ **Secondary:** _____

Policy Holder: _____ **Policy Holder:** _____

Date of Birth: _____ **Date of Birth:** _____

SS#: _____ **SS#:** _____

ID#: _____**Group#:** _____ **ID#** _____**Group#:**_____

Relationship: Self Spouse Parent Other _____ **Relationship: Self Spouse Parent Other** _____

ASSIGNMENT OF BENEFITS

I understand that Corning Eye Care will bill my medical insurance carrier for covered services.
If Corning Eye Care is not contracted with my insurance plan, payment will be due at the time of service, and I will be provided with an itemized statement with which I can bill my insurance carrier.

- I authorize and request that insurance benefits be made directly to Corning Eye Care on my behalf for all services furnished to me by any physician employed by Corning Eye Care or its affiliates.
- I am aware that I am responsible for the deductible, coinsurance and any non-covered services. Coinsurance and deductibles are based upon the change determination of my insurance carrier/carriers.
- If I do not have insurance I understand that payment will be due at the time of service.
- I understand that I am financially responsible for all charges whether or not paid by my insurance.

RELEASE OF INFORMATION

Insurance authorization, release of medical records, insurance benefits and assignments, responsibility of patient and acknowledgement

- Corning Eye Care, employees of its Medical staff (including your physician), and the independent contractor services have agreed, as permitted by law, to share your health information among themselves for the purposes of treatment, payment or health care operations. This enables us to better address your health care needs. This information is being provided to you as a supplement to The Notice of Privacy Practices given to you by Corning Eye Care. For the purposes of treatment, payment, or health care operations, I authorize the release of all medical records and any insurance information between Corning Eye Care, its affiliates, my family physician, insurance carriers and the Health Care Financing Administration to process claims for related services.
- I hereby authorize said assignee to release information necessary to secure payment.
- I allow for fax transmission and electronic submission of such information.
- A scan and/or photocopy of this assignment will be considered as valid as an original.

CONSENT FOR TREATMENT

I have read and fully understand the above consent for evaluation and treatment, financial responsibility, release of medical information and insurance authorization.

_____ _____ _____

Signature of Patient / Parent / Guardian / Conservator Date Reason patient is unable to sign

If you are an established patient, we apologize for any inconvenience, however, we are required to obtain a signature for insurance purposes and update all patient information annually. Thank you!

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Phone: (530) 824-2166

Financial Policy and Disclosure

Patient Legal Name: _____ DOB: _____

As we are dedicated to providing the most efficient and reasonable eye health and vision care services to you and your family, our office feels that your understanding of the financial and disclosure policy is also an essential component of the care. Therefore, it is necessary for us to have a Financial Policy and Disclosure statement to inform you of our requirements for payment for Services provided to patients.
All comprehensive exams at Corning Eye Care (which includes Diabetic Eye Exams) consist of a full eye health evaluation, which includes assessment for glaucoma and cataracts and a refraction to evaluate the visual system. Refraction Service is usually considered a **"non-covered"** service with most medical insurances. A Contact Lens Evaluation is an optional **"non-covered" by medical insurance** service which is an **additional** charge and may be performed on the same day or within thirty (30) days of the routine eye exam.

Medical and Vision Insurance Policy

- If you carry a medical insurance policy, it is our policy to file a claim with your insurance carrier as a courtesy to you. We must have accurate and complete insurance information at the time of service.
- If a service is provided and is not covered by your insurance company, you will be expected to pay at the time of service.
- If we have not received a payment from your insurance company within ninety (90) days, you will be responsible for the balance due.
- Estimated deductibles, co-payments, an estimated coinsurance will be collected before services are rendered for insurances with which we participate. The insurance company will determine the final financial distribution.
- In special cases, we may need your help in contacting your insurance company for the payment of your services.

*Our office will ONLY file to contracted/participating insurances. It is ***the patient's responsibility*** to provide our office with accurate billing information and to understand the insurance benefits and financial coverage. If the insurance plan requires a ***referral***, the patient is responsible to assure that the referral has been received by the referring office, before the exam.

Notice of Exclusion from Health Plan Benefits

Self-Pay Policy

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself.

- **You will be required to pay in full the same day that services are provided, at check out.**
- **Methods of acceptable payments are *Cash, LOCAL Bank Check or Visa/MasterCard/Discover/American Express.***
- **In order to provide the best medical care, we ask that you do not discuss your financial concerns with the physician(s) or medical staff. Please discuss any account information with the check out associate or receptionist.**

Divorce/Custody Case/Personal Representative Policy

- The parent or guardian who brings the patient into our office will be held financially responsible for the minor's medical expenses, regardless of the provisions in the divorce decree or custody arrangements, and regardless of the child's relationship to the insurance subscriber (if applicable).
- For situations where the patient is not able to sign legal documents, the personal representative, such as Power of Attorney, must provide notarized copies of necessary legal documents. He or she must be available to sign all documents, and must be present during the exam.

Worker's Compensation Policy

- If you are a worker's compensation patient, it is our policy to bill your employer or the worker's compensation carrier for services rendered.
- If payment is denied from your worker's compensation carrier, you will become responsible for the entire balance of your services. Payment will be due within ten (10) days following any worker's compensation payment denial.
- It will be your responsibility to contact us with the name and address of your employer or the insurance company that covers your employer.

Overdue Balances

- All overdue patient balances will be considered bad debt.

To help in this policy we ask that you assist us at the time of service by:

1. Providing us with current and updated information on yourself and your insurance company.
2. Presenting an updated photo identification card and insurance card when changes are made.
3. Making the appropriate payment at the time of service; whether it is a deductible, copay, coinsurance, refraction, or for the full amount if you are a Self-Pay Patient.

By signing below *I have read and understood the financial policies of **Corning Eye Care** and also I understand that Corning Eye Care reserves the right to change any and all fees at any time without notice. I authorize and request that insurance and all other pertinent benefits be made directly to Corning Eye Care on my behalf for all services furnished to me by any physician employed by Corning Eye Care or its affiliates. I authorize the release of any medical information about necessary to determine benefits for related services.*

_____ _____ _____

Signature of Patient / Parent / Guardian / Conservator | Date | Reason patient is unable to sign