



**WELCOME TO OUR PRACTICE!**

PATIENT NAME: \_\_\_\_\_ Please circle M F DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_  
SOCIAL SECURITY NO. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ PARENTS' NAMES (if minor): \_\_\_\_\_  
HOME ADDRESS: \_\_\_\_\_ HOME # (\_\_\_\_) \_\_\_\_\_ Cell # \_\_\_\_\_  
CITY/STATE/ZIP: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_ EMPLOYER PHONE# (\_\_\_\_) \_\_\_\_\_

PRIMARY PHYSICIAN \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

**INSURANCE INFORMATION**

SUBSCRIBERS NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

PRIMARY INS. CO. \_\_\_\_\_ ID# \_\_\_\_\_ GROUP# \_\_\_\_\_

INS. ADDRESS \_\_\_\_\_

SECONDARY INS. CO. \_\_\_\_\_ ID# \_\_\_\_\_ GROUP# \_\_\_\_\_

INS. ADDRESS \_\_\_\_\_ SUBSCRIBER'S NAME: \_\_\_\_\_

IN CASE OF EMERGENCY CONTACT: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ PHONE# (\_\_\_\_) \_\_\_\_\_

**FINANCIAL POLICY**

We will gladly bill your insurance for services rendered, we do this as a courtesy to our patients. However, to do so, we must have all insurance information provided to us before services are rendered or payment in full is required. We will not become involved in disputes between you and your insurance company regarding eligibility, deductibles, co-payments, covered charges, etc, other than to supply factual information as necessary. It is crucial you are aware of your insurance benefits. If your services are denied due to being a "non-covered benefit", or for medical necessity, time restrictions or failure to get a referral for your visit you are responsible for the timely payment of your services. *\*\*We reserve the right to charge for appointments cancelled or broken without 24-hour advance notice.*

**HIPAA COMPLIANCE**

\*\* I acknowledge receiving Peninsula Eye Physicians Privacy Notice. \_\_\_\_\_ (init.)  
\*\* I consent to allow Peninsula Eye Physicians to send recall cards and to leave messages at my home or cell \_\_\_\_\_ (init.)

**I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO MY HEALTH PLAN. AS STATED IN THE FINANCIAL POLICY, I ACCEPT FULL RESPONSIBILITY FOR ALL CHARGES RELATED TO MY MEDICAL TREATMENT.**

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

Patient, Parent if minor or guardian

UPDATED \_\_\_\_\_

## NON-COVERED SERVICE WAIVER

I have been informed by Peninsula Eye Physicians that the service today may not be covered by my insurance company for the following reasons:

**Refraction is not a covered benefit.**

*The refraction is the part of the eye exam that enables the doctor to give you a new glasses prescription or update your current one. The cost to you is \$50.00, to be paid at the time of service. We will bill the entire amount of the exam to your insurance and if the refraction is paid, we will reimburse the amount of the refraction to you. Although, the refraction is an important part of your exam, you may choose whether or not to have the refraction performed today. Please check one of the following:*

\_\_\_\_\_ I do wish to have a refraction performed

\_\_\_\_\_ I do not wish to have a refraction performed.

I am not able to provide a current insurance card at this time. I now will be considered “self-pay” and I will pay the full amount of my visit today. I understand that Peninsula Eye Physicians **will not** do retro-active billing for services rendered.

I do not have a valid referral or authorization from my insurance company. I now will be considered “self-pay” and I will pay the full amount of my visit today. I understand that Peninsula Eye Physicians **will not** do retro-active billing for services rendered.

As a Medicare patient, I agree to pay for non-covered services (i.e. Eye refractions, routine eye exams, eye glasses, contact lenses and certain medical supplies) or services deemed not medically necessary by Medicare. In addition, I authorize Medicare benefits to be made on my behalf to the physician supplier. I authorize the release of any medical information to the healthcare financing administration to determine these benefits.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

### Photo Release

\*\*I consent to have a photograph(s) taken of myself/my child \_\_\_\_\_ to be used for documentation or educational purposes.

SIGNATURE: \_\_\_\_\_ DATE \_\_\_\_\_