

Date _____

Patient

Name *Last* _____ *First* _____ *MI* _____ Home Phone _____

Address _____ *Apt #* _____ Additional Phone _____

City _____ *State* _____ *Zip* _____ Date of Birth _____

Social Security # _____ Age _____ Sex _____ Marital Status _____

Patient Employed By _____ Is Patient a Student? Yes No

Business Address _____

Occupation _____ Work Phone _____

Spouse's Name _____ Spouse's Social Security # _____

Spouse Employed By _____

Business Address _____

Occupation _____ Work Phone _____

Person with whom we may share your medical and financial records? _____ Relationship _____

Address _____ Home Phone _____

City _____ *State* _____ *Zip* _____

Responsible Party

Who is responsible for your bill? Patient Parent Workman's Comp Power of Attorney

Name *Last* _____ *First* _____ *MI* _____ Home Phone _____

Address _____ *Apt #* _____ Work Phone _____

City _____ *State* _____ *Zip* _____ Date of Birth _____

Social Security # _____ Relationship _____

Primary Insurance

Name of Policy Holder _____

SS # _____ DOB _____

Phone _____ Relationship _____

Name of Insurance Co. _____

Employer _____

Address _____

Secondary Insurance

Name of Policy Holder _____

SS # _____ DOB _____

Phone _____ Relationship _____

Name of Insurance Co. _____

Employer _____

Address _____

Referral

Who is your appointment with today? Dr. Berberich Dr. Hafner Dr. Johnson Dr. Stephenson
 Dr. Brightwell Dr. Harmon Dr. Moran

How did you hear about Kentucky Eye Care (i.e. Yellow Pages, friend)? _____

Referred by _____ Family Doctor _____
Name *Relationship* *First & Last Name*

Please present your insurance cards and one form of picture I.D. to the receptionist when you check-in. Thank you.

Financial Policy

Thank you for choosing Kentucky Eye Care as your vision care provider. The following is a statement of our Financial Policy which each patient must read and sign prior to receiving treatment. In addition, the reverse side of this form and a patient history needs to be completed before seeing the doctor.

Full payment is due at the time of service unless other arrangements have been made in advance. For your convenience, we accept cash or personal checks, as well as MasterCard, VISA, and Discover credit cards. We also offer an extended payment plan with prior credit approval. To establish an Extended Payment Plan, a payment application must be completed and approved before treatment is rendered.

Insurance - We participate with Medicare and many other commercial insurance carriers. You are responsible for contacting your insurance carrier to verify that Kentucky Eye Care is on your participating doctor list and to assure that your visit with us will be covered. If a referral from your primary care physician is required by your insurance plan, you are responsible for obtaining this prior to your appointment.

As a service to our patients, Kentucky Eye Care will file insurance claims for you. In order to file your insurance, we must have your complete and correct insurance information. If we are a participating provider with your insurance carrier, we ask that you pay only any co-pay, deductible amount, or percentage of charges for which the patient is responsible on the date of service. We will bill your insurance carrier for the remainder. All charges not paid by your insurance company will then be billed to you.

If Kentucky Eye Care is not a listed provider with your insurance carrier, or your vision care coverage and benefits are unclear, we require the balance of your account to be paid at the time of service with either cash, personal check or credit card, or that you be pre-approved on our Extended Payment Plan. We will bill your insurance carrier for all charges; however, if your insurance company does not pay, any balance on your account will be transferred to your credit card or the Extended Payment Plan. Please be aware that some, and perhaps all, of the services provided may be "non-covered" services and not considered reasonable and necessary under the Medical Program and/or other medical insurance.

Usual and Customary Rates - Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. Kentucky Eye Care participates with certain local insurance companies and the office accepts contracted amounts for services. However, you are fully responsible for all co-insurance amounts, deductibles, co-pays, and any non-covered services.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

"I have read the Financial Policy and understand and agree to all terms described above. I understand that I am financially responsible to Kentucky Eye Care, P.S.C. for all medical and surgical charges incurred by me or my dependents that are not covered by my insurance carrier."

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I have received notice of this organization's privacy practices.

Signature _____ **Date** _____

Please bring your medications, glasses, and/or contact lenses with you to your eye appointment. Thank you.