CENTER FOR SIGHT

Last:_____ First: _____ MR#:_____

Street Address: _____

City: _____ State: _____ Zip Code:_____

Home Phone: _____ Work Phone: _____ Cell: _____

Marital Status: _____ SS #: _____ Date of Birth: _____ Sex: Male___ Female___

Employer:_____ Phone:_____

Referring Physician or Family Doctor: _____

City: _____ State: _____ Office Tel #: _____

Insurance

Primary Insurance:_____ Patient's Relationship to Insured:_____

Subscriber SS# and DOB:_____

Secondary Insurance:_____ Patient's Relationship to Insured:_____

Subscriber SS# and DOB:_____

Do you have a Vision Plan (Avesis, EYEMED, VCP or VSP)? Yes _____ No _____

Vision Insurance:_____ Patient's Relationship to Insured:_____

Subscriber SS# and DOB:_____

If you have an eye problem not related to glasses or contacts, it is considered a medical visit.

Emergency Contact Information

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Is this visit the result of an accident? Yes No If yes, describe:_____

_____

_____

I attest that the above information is true and accurate.

Patient or Guardian Signature: _____

Acknowledgment of Financial Responsibility

Here at Center for Sight, we want to make sure you have the necessary information to be reimbursed for all covered services. Please understand your insurance only covers services when their rules are met.

Insurance coverage: It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and authorization requirements as well as vision services. This information is furnished by your insurance carrier. We make copies of your insurance cards assuming the coverage is active at the time of your visit. If your coverage is not in effect at the time of services, you will be responsible for payment.

Insurance Changes: If you have any changes in your insurance coverage, please notify us. Failure to do so may result in a claim denial and you will be billed.

Co-payments, Co-insurance, and deductibles: Co-insurance and co-payments are the patient's/subscriber's responsibility. Co-payments are due at the time of service. Deductibles are the responsibility of the patient/subscriber.

Refractions: A refraction is a non-covered service. There is a **$35 fee** for the refraction and it is due at the time of service. Most Vision Plans include the refraction in the office visit.

Routine Contact Lens Evaluation & Fitting: Contact lenses are medical devices regulated by the FDA. Your physician is required to evaluate the health of your eyes and fit your contacts every two years (*depending on how you wear your contacts, it might be one year*) in order to determine the best prescription for your eyes. For this service, all contact lens patients will be charged a contact lens fitting fee. Most vision and insurance plans require that this be billed separately and do not cover this fee, as contact lenses are considered to be "cosmetic." There is no charge for a follow up fitting within 45 days.

The Contact Lens fitting fees are as follows: Standard/spherical: $60, Toric/multifocal/astigmatism/soft $80, RGP/rigid/keratoconus: $120

Authorizations/Referrals: If your plan requires a referral, it is your responsibility to obtain it from your primary doctor prior to your visit. If you wish to be seen without a referral you must sign and comply with our missing referral form (ABN).

Insurance Payments: If by error, an insurance check is sent to you, it should be immediately forwarded to our billing office along with a copy of the explanation of benefits (EOB).

Self Pay Patients: Self pay patients must pay in full for the examination before any services can be rendered. If after your initial visit further testing is required, pricing will be discussed prior to any procedures.

★ Please note it is the patient's responsibility to be aware of their Insurance Company's requirements for each visit (referrals, copays, vision plans, refractions, etc.). I agree that I am responsible for payments or charges incurred by me or my dependent that are outside the scope of my insurance coverage, non-covered services or for which my insurance company pays me directly. I further agree to be responsible for the office visit if required referrals are not present at the time of visit.

Name of Patient (PRINT) Signature Date

Signature of Patient Representative Relationship to Patient Date