❖  ***EAST VIEW EYE CARE, P.C.*** ❖

PATIENT INFORMATION: ***Welcome to our office! Thank you for letting us serve you!***

Patient's NAME: Mr./Mrs./Miss/Dr. _____
(please print) (circle) Last First Middle

❑ Male ❑ Female Name you preferred to be called:_____

Age _____ **Date of Birth** _____/_____/_____ **Soc. Sec. #** _____-_____-_____

❑ Single ❑ Married **Race/Ethnicity:** (check all that apply) ❑ White/Caucasian ❑ Hispanic ❑ Black/African American

❑ Divorced ❑ Widowed ❑ American Indian/Alaska Native ❑ Asian ❑ Native Hawaiian/Other Pacific Island

Preferred Language: ❑ English ❑ Spanish

# of Children:_____ **Name of Spouse**:_____Spouse's Date of Birth:____/____/____

Name of parents/legal guardian(s) if patient is a minor:_____

Current Address: _____
street / box

_____
city, state, zip code Communication preference: ❑ email ❑ postal ❑ phone

Home Phone: **(_____) _____-_____** E-mail address:_____

Cell Phone: **(_____) _____-_____--->**❑ texting ok (check box if want free appt. notifications)

Work Phone: **(_____) _____-_____** Current Occupation: _____

Employer: _____ ❑ Retired ❑ Student: ___full time ___part time

In case of emergency, whom may we contact?_____ Phone #:_____

Relationship: ❑ parent/legal guardian ❑ spouse ❑ friend/neighbor ❑ other:_____

How did you first hear about our office?
❑ physician ❑ sign ❑ Internet ❑ phone book ❑ insurance/HMO ❑ other:_____

Whom may we thank for referring you to our office? Name: _____

PAYMENT POLICY:

Payment is due at time of service. We will file your insurance for you, as a courtesy to you, free of charge. However, all co-pays, deductibles, and non-covered services are due at the time of service. It is your responsibility that we have the correct insurance information in your file and that your insurance pays within a timely manner. Accounts with balances still unpaid from 90 days from the date of service, and/or the time of ordering materials, will incur an interest charge equal to 1.5% per month (18% APR) regardless if your insurance has paid or not. Please note there is a $25 fee on returned checks, and that applicable collection fees, attorney fees, and court costs will be added to your account if we have to turn your account over to our collection agency.

PAYMENT METHODS YOU PLAN TO USE TODAY: (check all that apply)
❑ **Insurance** ❑ **Cash** ❑ **Check** ❑ **Credit/Debit Card**

I AGREE TO ABIDE BY THE ABOVE PAYMENT POLICY.

X_____ _____ _____
Signature of Patient/Legal Guardian ***Print Name (of person signing)*** ***Date***

PRIVACY PROTECTION NOTICE:

As required by Federal HIPPA Law, we have provided you a copy of our Notice of Privacy Practices for our office. In addition, we have posted this notice on our web site (www.EastViewEyeCare.com) and in our waiting room.

I ACKNOWLEDGE THAT I HAVE RECEIVED A NOTICE OF PRIVACY PRACTICES FOR THIS OFFICE.

X_____ _____
Signature of Patient/Legal Guardian ***Date***

COMMERCIAL INSURANCE / MEDICARE WAIVER

Provider Notice:

Medicare and most insurance companies will only pay for services that are determined to be "reasonable and necessary" under 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 payment for that service.

Medical eye exams (except for refractions) are generally covered if the beneficiary has a complaint or symptom of an eye disease or injury. Coverage is **NOT** covered for routine vision exams or supplies for the following diagnoses:

Refractive Errors (such as: Myopia, Hyperopia, Ametropia, Astigmatism, Anisometropia, and Presbyopia)
Glasses and/or Contact Lenses (except one time after each cataract surgery)

Patients are responsible for any services that there insurance states as "non-covered" and their deductibles. It is the patient's responsibility to determine if the doctor is under their particular medical network.

REFRACTIONS are **NOT** covered under the Medicare program. Charges for refraction should be collected the same day as the exam. Charges may be filed to Medicare, but coverage will be denied.

Beneficiary Agreement:

"I request that payment of authorized Medicare or my other medical insurance benefits be made either to me or on my behalf to **East View Eye Care, P.C.** for any services furnished me by either provider from this date forward. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

"I have been notified by my physician in the above paragraphs that he/she believes that in my case Medicare, or my own individual medical insurance, is likely to deny payment for the services identified above, for the reasons stated. If my insurance denies payment, I agree to be personally and fully responsible for payment."

Patient's Name (please print):_____**Medicare #:**_____

X_____ _____
Patient's Signature **Date**

********** **MEDIGAP WAIVER** **********

I request that payment of authorized Medigap benefits be made either to me or on my behalf to East View Eye Care, P.C. for any services furnished me by that provider from this date forward. I authorize any holder of medical information about me to release to _____(Medigap ins. co.) any information needed to determine these benefits or the benefits payable for related services

X_____ _____
Patient's Signature **Date**

********** **TennCare Waiver Form** **********

(BlueCare, TennCare Select, Community Plan, etc.)

Patient's name: _____

- **I understand that patients under 21 are allowed to have:**
  - one routine eye exam per year (since the last routine eye exam)
  - medical eye office visits as needed (referral may be required)
  - one pair of glasses (CR-39 plastic lenses only)
  - one pair of replacement glasses (lost, stolen, or broken)
  - I also understand that I am totally responsible for all charges on contacts and all charges on any upgrades on the glasses such as tints or polycarbonate lenses.
- **I understand that patients 21 & over are allowed to have:**
  - medical eye office visits as needed (e.g. for cataracts, glaucoma, etc.) (referral may be required for some TennCare insurances)
  - I also understand that I am totally responsible for all charges on routine eye exams, contacts, and all charges on any glasses since **TennCare does not cover these items for adults**.

I understand and agree to all of the above, and allow East View Eye Care, P.C. to file the applicable TennCare insurance on my behalf from this date forward:

X_____ _____
Signature of Patient/Legal Guardian) **Date**