Patient Information

Last Name: ______________________________________ Legal First Name: ____________________________ Middle: _______

Preferred Name: _____________________________Birth Sex: ☐ M ☐ F Additional information: _______________________

Date of Birth: ________________ Age: ______ Social Security # : ____

Mailing Address: ____ City ___________________ State/Zip _____________

Cell: (___)_______________________ Work: (___)_________________________ Home: (___)_________________________

Email: ____ Contact me at: ☐ Cell ☐ Work ☐ Home ☐ Email ☐ Text

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow/er ☐ Other

Occupation: ____ Employer: ____

Spouse (or Parent if for a minor):__________________________ DOB:________________ Phone:______________________

Medical Insurance Information ☐ NONE	**Vision Insurance Information** ☐ NONE
Company:	Company:
ID #:	ID #:
Ins. Subscriber's Name:	Ins. Subscriber's Name:
Ins. Subscriber's DOB:	Ins. Subscriber's DOB:
Relation to Patient:	Relation to Patient:

Information of Person Responsible for Payment, if not the patient, complete the following:

Payer's Name: ____ Relation to Patient: _________________________

Mailing Address: ____ City ___________________ State/Zip ___________

Phone #: (___)__________ Social Security #: _________________________ Employer: ______________________________

Person(s) Allowed Access to your Health Information

Name: ____ Relation: _____________________________

Phone #: (______)________-_____________ *Is this your EMERGENCY CONTACT? YES / NO*

Name: ____ Relation: _____________________________

Phone #: (______)________-_____________ *Is this your EMERGENCY CONTACT? YES / NO*

Protected Health Information (HIPPA Disclosure)

I acknowledge that I have received the Notice of Privacy Practices from Cascade Optometry.

X ____ *Date:* ________________________

Signature

Financial Policies and Assignment of Benefits

Initials Here

____ Payment is due at time of service. For our patients with insurance, payment is due for the portion not covered by your insurance at the time of service.

____ As a courtesy to our patients, we will file your insurance claim after each visit. If your insurance company has not paid your claim within 90 days, you will be required to pay in full. Our office does not enter into disputes with insurance companies over coverage. It is your responsibility to resolve any dispute over payments by your insurance.

____ In the event that a billing statement is sent, you will have 30 days to pay any outstanding balance. Thereafter, finance/late charges of $15 per month will be added to your account. Should collections action be required, a $75 collection fee will apply. Non-sufficient funds charges on checks are $40. Statements may be sent via email.

____ Contact lens follow-up care will be charged $55 per visit beyond 90 days of exam or after a contact lens prescription has been finalized. Contact lens care beyond six months from contact lens exam will require a new exam fee.

____ If we are not on your insurance company's panel, we will provide you with an itemized receipt so that you may file a claim with your insurance company yourself for reimbursement. If you have any questions about this, please let us know.

____ **A missed appointment fee of $50 applies if less than 24 hours' notice was given for cancellation.**

_____ **Many patients have both medical and vision benefits. Vision insurance is designed to cover a prescription for glasses and help pay for lenses. It is not intended to cover medical conditions and treatments. Medical insurance applies to situations when a medical problem affects the eyes (Such as diabetes, cataracts, and glaucoma, to name a few.) When such conditions are being managed, we submit the claim to the medical insurance and co-pays, deductibles, and co-insurance will apply. Vision insurance does not cover these issues. We are obligated to comply with the regulations set forth by vision and medical insurance companies. Self-pay patient care will also be billed according to the service rendered.**

I understand my responsibility for payment as described above. I authorize Cascade Optometry to file my claim with the appropriate insurance based on the reason for the visit and the results of my examination. I hereby assign all medical benefits, to include major medical and vision benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health plans, to issue payment directly to Cascade Optometry for services rendered to myself and/or my dependents regardless of my insurance benefits, if any.

I hereby authorize Cascade Optometry to: (1) release any information necessary to insurance carriers regarding my illness and treatment; (2) process insurance claims generated in the course of examination of treatment; (3) allow a photocopy of my signature or digital signature to be used in processing claims for the period of lifetime. This order will remain in effect until it is revoked by me in writing. **I have requested medical services from Cascade Optometry on behalf of myself and/or dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full upon presentation of statement.** A photocopy or digital copy of this assignment is considered as valid as the original.

X ____ Date: _____________________

Signature