Bayview Vision Clinic

Patient Name_____________________________ Guardian Name _________________________________

Patient Date of Birth_____________ Gender_____ Employer_____________________________________

Mailing Address__________________________________ City______________ State____ Zip_________

Primary Phone__________________________ Email____

I consent to receive SMS text messages from BAYVIEW VISION CLINIC. Msg & data rates may apply. ☐ YES ☐ NO

SSN ___________________________________

Emergency Contact________________________Phone_______________Relationship_______________

Primary Care Doctor____________________________ Pharmacy_________________________________

Please bring your photo ID and Insurance cards to every appointment.

Although the information on the front of the insurance card may not change for you, there is information on the back that we need for claims submission that may change.

Medical Insurance (if card not provided) ________________________________Member ID___________

Vision Insurance (if card not provided) _________________________________Member ID___________

Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or any other insurers. You must pay for these services in full at the time of the visit. This includes but is not limited to: Refractions (glasses Rx) and contact fittings, contact lens materials and balance billing for glasses hardware and lenses.

Notice of Privacy Practices

We are concerned with your privacy rights. We are complying with national guidelines (HIPAA) to safeguard your personal health information. Consumer information is not shared with third-parties for marketing purposes.

We keep a record of the health care services we provide to you. You may ask to view and/or obtain a copy of that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or receive more information about it by contacting our privacy officer or any front office staff member.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information. If you would like a copy for your review, please request a copy from our reception staff.

By my signature below, I acknowledge being informed of your privacy practices, and my right to obtain a copy of the full "Notice of Privacy Practices." My signature also is acknowledgment & acceptance of the other policies listed above.

Signature ____**Date**_____________________

Bayview Vision Clinic Payment Policy

We are committed to providing you with quality health care. We have developed this to help patients understand their responsibility for services rendered at our clinic. If you have any questions, please do not hesitate to speak to our staff. Please read each of the policies.
By signing below, you acknowledge that you have read and understand each specific policy.

Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Copayments and deductibles. All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. It is your responsibility as the insured to know of any deductible you may have. Some or all services may be applied towards your deductible, please contact your insurance company if you have any questions on coverage.

Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or any other insurers. You must pay for these services in full at the time of the visit. This includes but is not limited to: Refractions (glasses Rx) and contact fittings, contact lens materials and balance billing for glasses hardware and lenses.

Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. **Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. We will attempt to bill once for insurance – if denied the balance becomes the patient's responsibility to pay the balance in full**.

Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Nonpayment. If your account is over 90 days past due, you will receive a phone call notifying you that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you, and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

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Patient Signature **Date**

Permission to Disclose Information

Patient Name:___________________________________ Patient Date of Birth:_____________________

Patient Email Address:___________________________

I give my consent to Bayview Vision Clinic to disclose my personal health information, treatment(s), appointment details, and payment information to the following person(s) listed below, if any:

Name:____________________________________ Relationship: ________________________

Name:____________________________________ Relationship: ________________________

Bayview Vision Clinic may leave a detailed message on my voicemail regarding current and future appointments that I have scheduled.
□ YES □ NO

Bayview Vision Clinic may send me an email to my personal email address that I provided regarding my personal health information, treatments, appointment details, and payment information.
□ YES □ NO

I consent to receive SMS text messages from BAYVIEW VISION CLINIC. Msg & data rates may apply. Reply STOP to opt out.
We will send SMS (text) messages infrequently, and only related to confirmation and reminders of appointments, notification of eyewear or other products available for pickup, requests for reviews of our services, and communication regarding insurance benefits. We will not use SMS (text) messages for third-party advertising or marketing purposes.
□ YES □ NO

I understand that I may change, suspend, terminate, and revoke any person from this list at any time, in writing. Furthermore, I acknowledge that Bayview Vision Clinic will NOT disclose any information to anyone who is not on this list.

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Patient Signature **Date**