NEW PATIENT FORM

Last Name:____________________ First Name: ____________________ Intial:__________

Date of Birth (Month/Day/Year): _____/_____/_____ SSN: ______________ Marital Status:____________

Address:____ Apt. #: ______________

City: ____________________ State: ____________________ Zip Code: ____________

Home Phone: ____________________ Employer: ______________________________

Work Phone: ____________________ Occupation: ______________________________

Cell Phone: ____________________ Email Address: ______________________________

Text Opt In: Yes / No

Insurance Information

Medical Coverage

Name Of Insured (if other than patient): ______________________ SSN: ____________________ D.O.B: __________

Insurance Provider: ______________________________

Group #: ____________________ Member #: ____________________

Vision Coverage

Name of Insured (if other than patient): ______________________ SSN: ____________________ D.O.B: __________

Insurance Provider: ______________________________

Group #: ____________________ Member #: ____________________

Reason for Visit

[ ] Eye Exam [ ] Contact Lens Exam/Fit [ ] Laser Consultation [ ] Other ____________________

Do You Currently Wear Glasses? Y / N

Do You Currently Wear Contact Lenses? Y / N If "Yes" Disposable / Gas Permeable

Have you been diagnosed with any eye diseases or had any eye surgeries? Yes / No If Yes, explain: ____________________

How were you referred to our office? (Circle one) Friend / Advertisement / Doctor / Other

Name of Referral source: ______________________________

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Patient Name: ____ **Date**______________________________

It is the intention of Insight Complete Eye Care to provide you with a clear understanding of our financial agreements and billing procedures in the hopes to prevent any misunderstanding. If you have any questions regarding these agreements, please notify the front office coordinator. Please take the time to read, initial, and sign the patient financial responsibility form.

______If you have medical and/or vision insurance it is your responsibility to fill out the insurance details on the patient form. Please provide your insurance card to the front office coordinator to bill your insurance carrier completely and accurately. If benefits cannot be determined at the time of service, or when there is any doubt, payment in full is expected. **Please be advised that a medical insurance card does not inform our office if a separate vision plan exists.**

_____Your insurance policy is a contract between you and your insurance company. We are not a party to that contract and cannot possibly know all of the details or specific benefits allowed by your insurer. As a service to you and upon your request we can bill your insurance company if we are a participating provider. However, at the time services are rendered if no insurance is presented we will collect on doctor services and materials in full. The responsibility of filing for reimbursement will fall on the individual.

_____You are responsible for payment of any unmet deductible, co-payment, and co-insurance as determined by your contract with your insurance carrier. **We expect these payments when services are rendered.** Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim you will be responsible for your balance in full.

_____If you have a vision plan in addition to your medial insurance please be advised that during your eye health evaluation **if a medical diagnosis and/or procedure is evident, fees accessed will be billed to your medical insurance** and all deductible, co-payments, and co-insurance will apply. Your vision plan is for routine vision exams and will not reimburse if a medical diagnosis exists.

_____If you are having a contact lens exam, evaluation, and/or fitting additional fees will be assessed. **This service is only billable to vision insurance and may not be covered in full.** We do not bill any contact lens services or materials to medical insurance. If contact lenses are deemed medically necessary due to cornea transplant, kerataconus, ectasia, etc, we will bill your vision insurance. Billing medical insurance for these diagnoses will be reviewed on a case by case basis and assignment will not be accepted.

_____There are normal and expected times that we will need to re-bill your insurance company. However, if there becomes a time when the costs of completing your billing are over and above the usual and customary time spent to process and follow-up on a claim, we will contact you. If at this time payment has not been received by your insurance carrier payment will be expected in full by you and you may pursue collecting personally. If you would like us to continue to pursue billing your insurance company, you will be charged $20.00 for the additional time spent on the claim as well as payment in full. The $20.00 charge will be for each consecutive sixty (60) days that we continue to work on the bill. If and when payment is received from your insurance carrier you will be reimbursed.

_____Once payment is received on your behalf from your insurance carrier any balances due for unmet deductible, co-payments, and co-insurance that have not already been collected will be billed to you. After thirty (30) days of the first bill, a 1% annual or minimum of $2.50 per month finance charge will begin to apply on your account. Any bill over ninety (90) days past due will be subject to collection procedures. Collection procedures include but are not limited to a final collection notice and an attempt to reach you by telephone. If you fail to make payment arrangements your account will be turned over to a professional collection agency.

_____Upon receipt of payment from your insurance provider, you may end up with a credit balance. Any overpayment will remain on your account as a credit to be used towards future services or material purchases. If you would like to be issued a refund, please let us know and we will issue a check within thirty (30) days of your verbal or written request.

_____There will be a $25.00 service charge for any returned check. After receiving a returned check, Insight Fort Worth will no longer accept a check on your account. Payments will have to be made using cash or credit card.

I have read the above policy regarding my financial responsibility to Insight Fort Worth for services performed to myself or the above named patient. I authorize my insurer to pay any benefits directly to Insight Fort Worth. I agree to pay the full and entire amount of all bills incurred by the above named patient, as well as any amount due after my insurance carrier has made a payment.

_______________________________ _______________________________
Patient Signature Patient Printed Name

_______________________________ _______________________________
Guarantor/Responsible Party Signature Guarantor/Responsible Party Printed Name

____
Date