Eye Doctor, MD, P.C. – 2024 Update Form

Patient Name: _____ ***Date of Birth:*** _____/_____/_____

CONSENT FOR TREATMENT and ASSIGNMENT OF BENEFITS - I authorize *Eye Doctor MD, PC* to provide medical treatment to myself and or my dependent. I request that payment of authorized Medicare, Medicaid or applicable private insurance benefits be paid directly to Eye Doctor MD, PC for services provided under their care.

RELEASE OF MEDICAL INFORMATION - I authorize Eye Doctor MD, PC to release necessary medical information to my insurance company, its agents, or any third-party payer in order for payable benefits for these services to be determined. I agree that I am responsible for updating my insurance and registration information with Eye Doctor MD PC as necessary.

REFERRALS/AUTHORIZATIONS - I understand if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit Eye Doctor MD PC is not responsible for obtaining my referral. If I do not have a referral, I am responsible for payment in full for services rendered. This payment will be collected at the check-out desk.

E-Prescribing – I understand Eye Doctor MD PC uses an electronic health record for medical records as well as e-prescribing medications to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. I agree that Eye Doctor, M.D., P.C. can request and use my prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

FINANCIAL RESPONSIBILITY - I understand that Eye Doctor MD, PC will file my insurance claims as a courtesy; however, I am ultimately responsible for full payment of all charges. All balances past due after 180 days, will start accruing an interest charge of 18%. I understand that all costs not paid by insurance are my responsibility unless otherwise prohibited by state or federal regulations. I agree to pay all past balances prior to my next visit. Accounts unpaid by the insurance carrier greater than 90 days will be billed to the me, the patient, and I am responsible for payment. Should collection proceedings or other legal action become necessary to collect an overdue account, I understand and agree that Eye Doctor MD PC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. I agree to pay all collection fees in the amount up to forty percent (40%) of the total unpaid balance due, plus court costs and filing fees incurred by Eye Doctor MD, PC. I understand and agree that should Eye Doctor MD, PC be awarded judgment relating to this agreement or any debt incurred thereof, I will pay a service charge of one and one-half percent (1-1/2%) per month, eighteen percent (18%) per annum, beginning on the date of judgment.

COLLECTION OF CO-PAYS AND DEDUCTIBLES – I agree to pay, at the time of service, any required co-payments, co-insurance and deductibles as well as charges for services which are not covered by my insurance. In addition, if I have a high deductible insurance plan (greater than $500) and have not met my deductible, I will pay $200 up front at the time of service. I understand I may/may not get a refund of the high deductible payment, depending on what the insurance covers or leaves to my responsibility.

I have read the above statements. I understand my responsibilities. I acknowledge that Eye Doctor MD, PC, will scan this document, destroy the original, and agree the scanned document is the same as the original and legally binding.

_____ _____

Signature of Patient or Responsible Party (Date)

_____ □ SELF _____

Printed Name of Patient or Responsible Party Relationship to Patient

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Self-pay procedures - Any self-pay procedures are as stated, self-pay, and will not be billed to insurance. Payment for these is due on the date the procedure is performed.

Refraction Fee / Glasses Prescription - Most insurance companies (including Medicare and Medicaid) do not cover the refraction fee. I agree to be personally and fully responsible for payment if I am given a prescription for glasses, contact lenses or both. □ _____ I want a refraction ($75.00) □ _____ I want a refraction and contact lens fitting ($75+$80 = $155.00) This is a self-pay service and must be paid on date of services are rendered. **If you have vision insurance, you can submit a receipt to them for reimbursement**. If not paid on date of service, an additional $20 fee will be added for billing costs.

FMLA Forms - I understand that there will be a $100 form fee for any FMLA paperwork (allowing 1 revision).

DMV forms - I understand that there will be a $25 form fee for any DMV forms.

Medical record copies - Medical records given on a CD for $25 or electronically faxed to a new provider. They will not be printed.

Convenience fees - For all product sales (not including copays) there will be a 3.5% convenience fee applied if paying with credit/debit card or Venmo. This does not apply if paying with cash, check or Zelle.

MISSED APPOINTMENTS / SAME-DAY CANCELLATIONS – If I miss an appointment or fail to give at least 48 hours' notice of cancellation, I may have a $100 "no show" fee or a $50 "rescheduling fee". I understand that Eye Doctor MD PC does not make reminder phone calls but can set up for text or email reminders. I understand if I want reminders, I need to ask for this to be set up.

RETURNED CHECKS – I understand there is an additional $100 charge for any check that is returned for insufficient funds.

I have read the above statements. I understand my responsibilities. I acknowledge that Eye Doctor MD, PC, will scan this document, destroy the original, and agree the scanned document is the same as the original and legally binding.

_____ _____

Signature of Patient or Responsible Party (Date)

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I understand I have access to a copy of the "Notice of Privacy Practices" for Eye Doctor MD, P.C. (available online or on paper if requested). **The summary of the Notice of Privacy Practices is that we do not use or sell your information to any companies for any purpose other than your medical care. Your information is only used for your medical care.**

AUTHORIZATION FORM FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We have explained that disclosures may be made to family and friends related to the patient's health. It has also been explained that we will only disclose information relevant to current treatment. By signing below I authorize Eye Doctor MD, P.C. to disclose health care information to the following individuals (list all that apply):

(Please check columns as appropriate)	Name	In Person	By Phone	Ok To Leave Voicemail	Phone Number	Effective Dates? Check box if forever
Spouse/Partner						
Parent						
Sibling						
Child						

Please initial the applicable items below:

Eye Doctor MD, P.C. staff have my permission to leave

□ ____ Appointment Information □ ____ cell phone voice-mail,

□ ____ Medical Information □ ____ home voice-mail,

□ ____ No information □ ____ work voice-mail.

IF CHANGED, PLEASE UPDATE PHONE NUMBER ADDRESS, EMAIL ETC BELOW.

_____

_____

_____

_____

_____

(Signature of Patient) (Date)

_____

(Signature of Patient's Representative) (Date)

_____

(Printed Name of Patient's Representative) (Relationship to Patient)