Washington Eye Institute

7500 Greenway Center Dr #300, Greenbelt, MD 20770
301-277-4844 Fax: 301-927-3221

<table>
<tr><td colspan="4">Thank you for choosing our office. In order to serve you, PLEASE PRINT the following information</td></tr>
<tr><td colspan="4">Name:</td></tr>
<tr><td colspan="2">Street Address:</td><td colspan="2">City/State/Zip</td></tr>
<tr><td>SSN</td><td>Birthdate</td><td colspan="2">Gender</td></tr>
<tr><td>Home Phone</td><td>Work Phone</td><td colspan="2">Cell Phone</td></tr>
<tr><td colspan="2">E-mail address</td><td colspan="2">Other Phone</td></tr>
<tr><td>Emergency Contact Name 1</td><td>Emergency Contact Phone</td><td>Emergency Contact 2</td><td>Emergency Contact phone</td></tr>
<tr><td colspan="2">If the Patient is a child, who may authorize treatment</td><td colspan="2">Relationship</td></tr>
<tr><td colspan="2">Person Financially responsible for treatment if not Self</td><td colspan="2">Phone</td></tr>
<tr><td colspan="2">Primary Insurance Policy Holder</td><td>Relationship</td><td>DOB</td></tr>
<tr><td colspan="2">Secondary Insurance Policy Holder</td><td>Relationship</td><td>DOB</td></tr>
<tr><td colspan="2">Tertiary Insurance Policy Holder</td><td>Relationship</td><td>DOB</td></tr>
<tr><td>Primary Care Physician Name/Phone/ Address</td><td colspan="2">Person/Physician who Referred you</td><td>Previous Eye Physician</td></tr>
</table>

Race (circle one): African- American Asian Caucasian Hispanic Other Decline to Provide

Ethnicity (circle one): Hispanic/Latino Non-Hispanic/Latino Decline to Provide

Language (circle one): English Spanish Other:__________________ Decline to Provide

I understand that office visit charges are payable on the day service is rendered. I authorize Washington Eye Institute to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Washington Eye Institute and myself.

Signature:____ **Date:**_________________________

WASHINGTON
EYE INSTITUTE

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Greenbelt, MD 20770

FINANCIAL POLICY

At Washington Eye Institute, LLC, we are committed to providing you with the highest level of service and quality care. As a courtesy, we will file a claim with your insurance company for you. Please provide our practice with your insurance information, including photo ID and your insurance card to help you receive your maximum allowable benefits. Please understand that all financial liability rests with the patient and not the insurance company. This means that the patient is responsible for any payments that are not paid by the insurance company.

Insurance Companies and Non-covered Services:

Our office participates with many major insurance companies. It is a patient's/ parent's/ guardian's responsibility to:

- Be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles.
- Find out from your insurance company whether or not the insurance company will cover the service being provided.
- Bring all of your current insurance cards to all visits.
- Provide our practice with current information including address, phone numbers and employer.
- In accordance with your insurance contract, you must be prepared to pay your co-pay and/or deductibles at each visit.

We accept cash, checks and most major credit cards for services.

- Evaluation and purchasing of contact lenses are frequently not covered by insurance companies, which our practice participates with. Full payment is due from the patient at the time of service and when ordering contact lenses.
- *Most insurance companies, including Medicare, do not cover refraction.* Our office fee for refraction is **$50.00**, and this fee is collected at the time of your visit in addition to any co-payments and/or deductibles.
- We provide medical, surgical, and cosmetic ophthalmologic care to our patients and while we provide routine eye examinations—when the patient has no medical complaints, we do not accept *ANY* vision plans or bill health insurances for these exams. You may submit a claim to your insurance to try and seek reimbursement for routine services. Our charges for examinations are available upon request.

**If you do not have a medical complaint you may be financially responsible for all charges at the time of service. **

Outstanding Balances:

We appreciate prompt payment in full for any outstanding balance. If your account is turned over to a collection agency, you agree to pay fees imposed by the collection agency in order to collect the overdue amount. Any check payments that do not clear the bank will be subject to a $25.00 returned check fee.

Referrals:

If you have a managed care plan that requires a referral to see a specialist, you *must* obtain a referral in order for your visit in our office to be covered under your medical insurance. If you do not have a valid referral your appointment will be rescheduled to the next available date.

Refraction (Glasses Prescription) Service and Fee:

If you receive a prescription for glasses or contact lenses you will be charged the refraction fee of **$50.00**, which will be collected at the time of your visit.

Forms:

There is a charge for completing various forms, including DMV vision forms. Pre-payment is required for completing forms, or for extra written communication by the doctor.

Cancellations/No Shows :

If you are unable to make your appointment, it is important that you call us at (301) 277-4844 as soon as possible so we can make other arrangements. We ask that you give us 24 hours' notice for office visits and 1 week for procedures, to avoid a missed appointment fee. No-Show/ Late Cancellation Fee for office visit is $25.00 and for procedures is $250.00.

Minors/Dependent Patients:

For all services rendered to minor/dependent patients, we expect payments from the minor's parent or legal guardian. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth and social security number. We request that you inform the subscriber that their insurance has been used.

Your signature indicates that you have read, understand and agree to the financial responsibilities, policies, and procedures of our office.

______________________________	______________________________
Signature of patient/guardian	Date

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Printed name of patient