Milpitas Optometric Group

We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to confirm the following information. Please review all completed areas to ensure that the information we have is current and accurate.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name ______ MI ______ Last Name ______ Date of Birth ______

Street Address ______

City ______ State ______ Zip Code ______

Home Phone ______ Day Phone ______ Cell Phone ______

Email Address ______

Guardian ______ Emergency Contact ______ Emergency Phone ______

Name

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the Notice of Privacy Practices from Milpitas Optometric Group, Inc.

Signature　　　　　　　　　　　　　　　　　　Date

If signing as a personal representative, describe relationship to the patient and the source of authority to sign this form.

Personal Representative Signature　　　　　　　　　　　　　　　　　　Source of Authority

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits and I request that payment of these benefits be made either to me or on my behalf to Milpitas Optometric Group, Inc for any services and materials furnished.

I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS-1500 form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown and authorizes my doctor to act as my agent, as above.

Lifetime Patient Signature　　　　　　　　　　　　　　　　　　Date

Name

FINANCIAL POLICY

Payment Patient agrees to pay for all portions of services due in full at the time services are rendered in our office. Our office accepts Visa, MasterCard, Discover, Care Credit, Checks and Cash. Returned checks are subject to a $25.00 fee, if checks are not paid within one week of being returned to our office. We report to the Santa Clara County District Attorney's Bad Check Program. Balance older than 30 days will be subject to additional collection fees and interest charges of $10.00 per month.

Ins. Card Patient understands requirement to present a valid insurance card at every visit and as needed throughout care in order to properly bill insurance. If a card is not provided or plan is not active, patient will be responsible for payment in full within 30 days of first notification.

Insurance We bill most insurance carriers for you if proper paperwork is provided to us. Any outstanding balances, co-payments, co-insurance, deductibles and denial of coverage are due within 30 days of your first notification. Although we are able to preauthorize most services, all quotes from insurance companies are not a guarantee of payment. The patient is responsible for all fees for services.

Our office does not participate in any HMO network groups. We will not bill insurance claims on patients behalf for any HMO claim and payment is due in full at the time of service.

Medicare We are Medicare Participating Providers for professional services only. We will bill your secondary insurance that automatically crossover through CMS (Medicare System). If your secondary insurance does not crossover, the balance due for coinsurance, co-pays, deductibles or denials is due once Medicare has processed the claim. All Medicare non-covered services (Such as eyeglasses and refraction) will be due as service is rendered.

Collections If balances are not paid at the time of service, the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections, patient agrees to pay all additional fees assessed in the collection of the debt. These fees include collection agency fees and attorney fees.

Screening Because insurance is designed to cover only a basic eye examination, it does not cover advanced screening tools. These screening tools assist in the care we provide and are offered at the rate indicated below. If you do not wish to receive these services, please inform the technician before services are rendered.

- ☐ OPTOMAP retinal screening photography is offered at $39.00
- ☐ iWELLNESS OCT screening is offered at $39.00

Contacts Success with one type, brand, style, or size contact lens does not indicate success with another. A change in any parameter or type of lens necessitates careful follow-up evaluations to ensure compatibility with your unique physiology and vision. Should you choose to wear contact lenses, an evaluation is required yearly to maintain a valid prescription. Contact lens evaluation, fitting and refitting charges may not be covered by routine vision or medical plans. Our staff is happy to discuss your options and cost before services are rendered. Payment for contact lens services is due in full when services begin.

Signature ______________________ Date ______________

VISION INSURANCE INFORMATION

I currently have the following Vision plan: ______________________
Name of Vision Insurance Company

The member for the Vision plan is: ______________________
Insured's Name

The member's date of birth: ______________________
Insured's DOB (MM/DD/YYYY)

The member's employer: ______________________
Insured's Employer (Name of Company)

SECONDARY VISION INSURANCE INFORMATION

I currently have the following Vision plan: ______________________
Name of Vision Insurance Company

The member for the Vision plan is: ______________________
Insured's Name

The member's date of birth: ______________________
Insured's DOB (MM/DD/YYYY)

The member's employer: ______________________
Insured's Employer (Name of Company)

MEDICAL INSURANCE INFORMATION

Some procedures are payable by major medical plans based on medical necessity. Our receptionist will request a copy of your medical card upon arrival. Please provide your major medical information below:

I currently have the following Medical plan: HMO PPO

UNITED HEALTHCARE CIGNA ANTHEM AETNA BLUESHIELD

KAISER OTHER: ______________________

The member for the Medical plan is: ______________________
Insured's Name

The member's date of birth: ______________________
Insured's DOB (MM/DD/YYYY)

The member's employer: ______________________
Insured's Employer (Name of Company)