

**We are delighted you have chosen us for your eyecare needs 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

\_\_\_\_\_  
Guardian Emergency Contact Emergency Phone

Race  American Indian or Alaska Native  Native Hawaiian or Other Pacific Islander  
 Asian  White  
 Black or African American  Declined to specify  
 Hispanic or Latino

Other Race \_\_\_\_\_ Ethnicity \_\_\_\_\_

**What Is The Best Method Of Contacting You?**  Phone  Text  Email

\_\_\_\_\_  
Best Phone # to reach you at Cell Phone

\_\_\_\_\_  
Email Address

**PLEASE VERIFY YOUR INSURANCE INFORMATION BELOW:**

**Vision Plan:**

**Medical Plan:**

\_\_\_\_\_  
Primary Vision Insurance Company

\_\_\_\_\_  
Primary Medical Insurance Company

Insured Info:

Insured Info:

\_\_\_\_\_  
Insured's Name

\_\_\_\_\_  
Insured's Name

\_\_\_\_\_  
Insured's Date of Birth

\_\_\_\_\_  
Insured's Date of Birth

**How were you referred to our office?**

Insurance List  Yelp  Practice Website  Friend  Other  
 Facebook  Yellow Pages  Insurance Website  Relative \_\_\_\_\_

**If referred by a friend or relative, please let us thank them (Name):**

Name \_\_\_\_\_

**Have you had the opportunity to visit any of our web pages?**

Facebook  Yelp  Practice Website  VSP Website

## 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

## 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.

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**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.

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**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.

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**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.

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**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.

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**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

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**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.

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\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date