Advanced Eyecare

Patient Name: _____

Male/Female/Ethnicity: _____ Date of Birth:_____ SSN:_____

Address: _____ City:_____ State: _____ Zip:_____

Phone Number Home: _____ Cell: _____Work:_____

Email: _____ Marital Status: _____

Place of Employment: _____ Occupation: _____

Primary Care Doctor:_____ Pharmacy:_____

Guarantor information (if patient is a minor or if patient is not the primary person insured)

Name: _____Date of Birth: _____SSN:_____

Address: _____City:_____State: _____ Zip: _____

Phone number Home: _____Cell: _____Work: _____

Email: _____ **Referred by**: _____

For Medicare patients: Advanced Beneficiary Notice (ABN): Sometimes there are services your doctor will perform that are not paid for by Medicare. The refraction (how we determine your eyeglass prescription) is one of these services. You personally will have to pay for this service. The refraction is $58.00. We want to let you know this in advance so you may make an informed decision. Please choose one option below (Please circle).

1. Yes, I would like to receive this service.
2. No, I do not want to receive this service.

Insurance and Financial Agreement: We will help you with your claim, but if your insurance company delays their reimbursement beyond 30 days, you will be expected to pay for services rendered.

I agree that should this account be placed with an attorney and/or collection agency for collection, to pay a minimum collection fee of 33% in addition to the amount due, no less than $20.00.

Communications Regarding my Accounts

Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any services and/or collectors of my accounts, through various means such as cell, land line, text, email, auto dialer, etc.

I have been given the opportunity to review Advanced Eyecare's **HIPPA** policy.

_____ _____

Responsible Party Signature Date


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