Eye See Clear Vision

928 Curlew Road, Dunedin Florida 34690

Today's Date _____

Reason For Visit? □ Routine Eye Exam □ Medical Eye Problem □ Other

First_____ Last_____

Address_____

Cell Phone_____ Home Phone_____

Email_____

Date of last Eye Doctor Visit: _____

Medical Insurance Carrier Name_____ Policy Number _____

Last 4 Social Security Number_____

Do You Have Vision Insurance? Carrier Name □ VSP (Cigna) □ EyeMed (Aetna) □ Spectera (UHC) □ Other

Pharmacy Name_____ Pharmacy Phone _____ Pharmacy Fax _____

Emergency Contact(s) First_____ Last _____Phone _____

Please list any eye surgeries and the surgeon who performed.

_____

List all medications you are taking (Attach List or Have Technician Copy)

_____

Please Check if you Had any of the following Conditions.

□ Asthma	□ Kidney Disease	□ Heart Murmur	□ Bleeding Problems
□ Rheumatic Fever	□ Diabetes	□ Psychiatric Treatment	□ Heart Trouble
□ Liver Disease	□ Cancer	□ Sinus Trouble	□ High Blood Pressure
□ Stroke	□ Joint Replacement	□ Ulcers	□ Other
□ Pregnancy (check if currently pregnant)			

Are you happy with your current prescription glasses? □ Yes □ No

Are you happy with your current prescription sunglasses? □ Yes □ No

Are you happy with your current contact lenses? □ Yes □ No

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered to be part of your treatment arrangement. The following is our Financial Policy, which we require you to read prior to any treatment.

All patients must complete our Registration and History forms before seeing the doctor. You must supply us with both your insurance card and driver's license prior to your visit.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, AND ALL MAJOR CREDIT CARDS.

Statement of Financial Responsibility
I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all the expenses incurred.

Notice of "Non-Covered" Services
I am aware that some services performed by Eye See Clear Vision may be considered "non-covered" by my insurance carrier or Medicare, therefore I will become fully responsible for payment of these services.

For patients with "Out-of-Network" coverage there is a Waiver of "Usual, Customary and Reasonable" Clause. I acknowledge that the fee charged by Eye See Clear Vision for services rendered to me, or to the person for whom I assume financial responsibility, may exceed the fee considered "usual, customary and reasonable", due to specialized services and staff. However, I agree to pay Eye See Clear Vision fees in full, even if the amount is greater than what I am reimbursed from my insurance company.

Missed Appointments
Unless canceled at least 48 hours in advance, our policy is to charge for missed appointments. The current rate is $50.00.

Procedures
We will ask that you pay 100% of any outstanding deductible/co-insurance prior to your procedure. This is due no later than 3 days prior to your procedure. Any refunds due to you will be sent 7-10 days after you have incurred the refund.

Bill To/Payment Instructions

_____ Commercial Insurance/Third Party Payor _____ Medicare _____Medicaid
Initial Initial Initial

I hereby authorize Eye See Clear Vision to bill my insurance company and/or Medicare (indicated or initialed above) for services provided to me and request that payment for such services be made to Eye See Clear Vision on my behalf.

List Names of Those Whom You Want Us to Share Your Financial Responsibility Information:

Name: Relationship:

_____ _____

_____ _____

Financial Agreement
The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the service to be rendered to the patient, he/she obligates himself/herself to pay the account with Eye Clear See Vision in accordance with the regular rates and terms of Eye Clear See Vision. Should the account be referred to an outside agency or an attorney for collections, the undersigned agrees to pay reasonable collection and attorney fees for collection expenses.

Billing Questions
Please address all billing questions to our Central Business Office (727) 222-2020.

Payment Plans
You can call our Central Business Office to determine if you qualify for this arrangement.

Patient Name: _____ Patient Signature:_____
(please print)

Legal Guardian:_____ Guardian Signature _____
(please print)

_____ _____
Witness Date

EYE SEE CLEAR VISION

HIPAA Consent

I understand that as part of my healthcare, Eye Clear See Vision originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means for communication among health professionals who contribute to my care, such as referrals
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually rendered
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff.

Please Print

Restrictions

I request the following restrictions to the use or disclosure of my health information:

_____

_____

Please tell us with whom we may discuss your protected health information:

(Example: spouse (name), children (name(s)), other relatives (name(s), friends or caregivers (name(s))

_____

_____

Messages or Appointment Reminders

May we leave a message at your home using doctor's/practice name: ☐ Yes ☐ No

May we leave a message at your cell using doctor's/practice name: ☐ Yes ☐ No

May we leave a message at your work using doctor's/practice name: ☐ Yes ☐ No

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e. referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law. I fully understand and ☐ accept ☐ decline this consent.

Notice of Privacy Practices

I acknowledge that I have been informed of Eye See Clear Vision's Notice of Privacy Practices that provides a description of Protected Health Information use and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this statement. I understand that the Eye Clear See Vision reserves the right to change its Notice of Privacy Practices that will be effective for health information Eye Clear See Vision already has about me, as well as any they receive in the future. Eye Clear See Vision will post a current copy of the Notice. I understand that I may obtain a copy of the current Notice in effect upon request. I have read all of the above and understand/agree to all the provisions therein regarding responsibility for payment, permission for treatment and Notice of Privacy Practices.

_____ _____

Patient/ Guardian Signature Date

_____

Printed Name of Person Signing Consent Form

If other than the patient is signing, are you the legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations? ☐ Yes ☐ No

PATIENT CONSENT

Request for Care and Consent for Treatment
The undersigned consents to the medical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider, which may include but are not limited to laboratory procedures, X-ray examination, medical or surgical treatment or procedures or other services rendered to the patient under the general and special instructions of the patient's physician. Eye Clear See Vision has the right to refuse to treat you if you refuse to sign this consent or if, at any time, you choose to revoke this consent.

Permission for Treatment
Permission is hereby granted for physicians and employees or agents of Eye Clear See Vision to render such medical and surgical treatment as is deemed necessary to the patient named below.

Assignment of Insurance Benefits
I authorize payment directly to Eye Clear See Vision of any insurance benefits otherwise payable to me for services, at a rate not to exceed Eye Clear See Vision regular charges for such services**.**

Authorization to Release Information
I authorize the release of medical records and related information from Eye Clear See Vision to authorized representatives of my third party payor or provider related to my care. I authorize review of records for any necessary agency audit and the release of the physician plan of care and discharge summary from my medical record upon my transfer to or from another health care facility.

Communication
By providing my email and phone number(s), I authorize Eye Clear See Vision to provide me information regarding my appointment (e.g. visit reminder), billing status, clinical research, and/or educational material that may be related to my condition(s), in addition, to periodically inform me of Eye Clear See Vision services/community events and requesting feedback regarding my experience with Eye Clear See Vision. I can opt out at any time by emailing phil@eyeseeclearvision.com to make this request. I understand that emailing confidential information may not be a HIPAA compliant secure form of communication and that Eye Clear See Vision does not monitor emails for specific patient care.

I authorize Eye Clear See Vision to enroll me in its secured patient portal that may also include the above information along with my clinical test results and medications. I understand that I should not rely on the portal to communicate important or emergency information regarding my specific care.

I authorize Eye Clear See Vision to include my patient survey or online review comments on its website or promotional material (note: your last name will not be used).

The undersigned certifies that he/she has read the foregoing, received a copy thereof and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms.

_____ _____
Patient/Guardian Signature Date

_____
Printed Name of Person Signing Consent Form

If other than the patient (Patient Name)_____ is signing, are you the legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations? ☐ Yes ☐ No