WELCOME TO OUR OFFICE

Please take a few minutes to answer the following questions to help us in your care.

Name (Last, First, MI) ____ Title (Mr, Mrs, etc) _______

Address _____________________________________ City _______________________ State __________

Zip Code ___________________ Email____

Home Phone_________________ Work Phone_________________ Cell Phone/Other__________________

Date of Birth______________ SSN_______________________ Marital Status______________ Sex______

Pref. Language_________________ Race_____________ Ethnicity (Pick one): **Hispanic** **Not Hispanic**

Employer____ Employer's Phone_________________

Emergency Contact_______________________________ Emergency Contact's Phone_________________

Insurance Holder's Name (Last, First, MI)____

Date of Birth_____________________SSN____

*********************************INSURANCE INFORMATION**********************************

We participate with many insurance carriers (please check with your insurance carrier to see if we are in your insurance network). It is your responsibility to know your insurance coverage. You are responsible for all co-pays, deductibles and any uncovered services which may include a $20 fee for refraction (measurement for glasses/contact lens prescription). Please bring us your card so we may copy it for our files. **If we perform a comprehensive exam (dilated or un-dilated) and find a medical issue, your medical insurance will be billed. It is your responsibility to inform us if you do not wish to have a medical exam performed (i.e. "I just want to be measured for glasses").** If you have both medical and vision insurance, and you are here for a medical exam, your medical insurance will be billed first. If we do not participate with your carrier, you are responsible for the cost of the exam at the time of service and it is up to you to seek reimbursement directly from your carrier. If you are uninsured, you are responsible for the cost of the exam at the time of service. Thank you in advance for your help.

"I request that payment of authorized medical benefits be made payable on my behalf to **South Michigan Ophthalmology** for any services furnished to me. I am aware that South Michigan Ophthalmology is accepting assignment and I am responsible for all co-pays, deductibles, and any uncovered services by my insurance plan including any refraction fees. I authorize the holder of medical information about me to release this information to the insurance carrier for any benefits and claims."

"I am financially responsible for any balance due because of co-pay, deductible, referral/authorizations not obtained prior to visit, or incorrect insurance information"

If authorization is required by your insurance carrier, it is your responsibility to obtain this prior to your visit.

"I understand my rights to privacy under the HIPAA privacy act and that South Michigan Ophthalmology will not disclose any of my information without prior written consent." (Information available upon request)

** There will be a $25.00 non-sufficient funds fee for returned checks **

** Patients will be liable for any collection and attorney fees **

Medical Records Fees: $1.00 per page for the first 20 pages, $0.50 per page for pages 21-50, $0.23 per page for pages 51+

SIGNATURE: ____ DATE: _____________