



Plainfield Ophthalmology

Comprehensive Eye Care with Compassion

PATIENT REGISTRATION FORM

Today's Date _____

PLEASE FILL FORM OUT ENTIRELY

Patient Name _____

Address _____

City _____ State _____ Zip _____

Preferred Phone _____ Secondary Phone _____

DOB _____ Gender Identity: M F X

Email Address _____ Marital Status: M S D W

Employer _____

Referring Doctor _____

Preferred Pharmacy _____ Cross Streets _____

INSURANCE INFORMATION (we do need this part filled out)

Primary Insurance _____

ID# _____ Group# _____

Name of Policy Holder _____ DOB _____

Secondary Insurance _____

ID# _____ Group# _____

Name of Policy Holder _____ DOB _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Plainfield Ophthalmology to submit claims to my insurance company and request payment for services rendered. I certify that the information I have reported regarding my insurance coverage is correct and further authorize the release of any necessary information, including medical information, to said insurance company. I permit a copy of this authorization to be used in place of the original.

I understand that I am responsible for all outstanding balances regardless of insurance coverage.

Patient/Guardian Signature _____ Date _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

I will receive upon request the Notice of Privacy Practices. I will be provided an opportunity to review it. The Notice of Privacy Practice states that we will not give out your information, unless you authorize us to do so in writing.

Patient/Guardian Signature

Date

FINANCIAL POLICY

All services performed are the financial obligation of the patient or responsible part. You are responsible for anything the insurance does not cover. Co-payments are due at the time of service. If you are unable to make your payment at your visit, your appointment may need to be rescheduled.

PPO Plans

Please verify with your insurance plan that your specific physician is contracted with your plan. This will help to ensure your services will be paid by your plan at the highest rate. We are required under our contract with the plan to collection any co-payments. We will bill you for any deductible or co-insurance amount.

HMO Plans

A referral is required from your Primary Care Physician before any service is rendered. If you do not obtain a referral, signing this Financial Policy indicates that you accept full responsibility for payment of these services. Alternatively, you can reschedule your appointment until you receive the required referral from your Primary Care Physician. We will bill you for any deductible or co-insurance.

Medicare

We accept assignment for Part B Medicare patients. You may be expected to pay your deductible and a 20% co-insurance after the insurance pays.

Medicaid

If your coverage is active, we will file your claim. Please bring proof of coverage to each visit. Contact Lens fitting and maintenance fees are not covered and must be paid at the time of service.

Worker's Compensation

We accept patients with Worker's Compensation coverage. This coverage (as well as accident information) must be verified and a claim number obtained prior to being seen by a physician.

Self-Pay

Please be prepared to pay for services at the time of service.

Time Allotment

We allow 90 days for claims to be paid by insurance companies. Following that period, you will be asked to pay. Statements are sent out by mail, email, and text. Accounts with unpaid balances after patient statements have been sent out for 90 days may be forwarded to a collection agency. You agree to reimburse us the fees of any collection agency, which will be added to the account at the time it is placed with the agency, and may be based on a percentage of the total balance at a maximum of 25% of the debt. You agree to also be responsible for all costs and expenses (including reasonable attorneys' fees) we incur in such collection efforts.

Returned Check Fee

Non-Sufficient Funds (NSF) checks are subject to a \$30.00 fee (in addition to fees from your bank).

No-Show Policy

A 24-hour notice is required to cancel any appointment, or you may be charged a \$30.00 "No Show" fee.

I have read and fully understand the above statements regarding payment policies. I understand that I am fully responsible for all outstanding balances, regardless of insurance coverage. I authorize assignment of benefits to Plainfield Ophthalmology, MD, SC and/or any physicians that care for me at this office.

Patient/Guardian Signature

Date

RESPONSIBLE PARTY FOR MINOR OR DISABLED PERSON

Patients 18 and Over will be responsible for their own accounts

Name _____ DOB _____
Address _____ City _____ State _____ Zip _____
Phone Number _____ Sex: M F Relationship _____
Email Address _____

REFRACTION AND CONTACT BILLING

A refraction is used to determine whether you are in need of a glasses prescription, as well as the best possible visual acuity/function of your eye. For example: if a patient is experiencing blurred vision or decrease in visual acuity, a refraction would need to be done to check for a medical issue. Appointments for Cataract Evaluation are required to have a refraction to determine whether or not cataract removal is necessary. This is **NOT** a covered service by Medicare and most other insurance plans.

\$55 will be billed to your insurance

I understand that I am fully responsible for the payment of any and all charges if these charges are not covered by the assigned benefits. I understand I may pay these fees at the time of service.

Patient/Guardian Signature

Date

With each annual visit, it is necessary to take measurements of the eye in order to properly prescribe contact lenses. The fee for a contact lens fitting varies depending on which lens is prescribed. These fees include a glasses prescription. **Patients with Medicaid must pay these fees at the time of service, they cannot be billed.** The fees are as follows:

New Patient Contact Lens Fitting: **\$165.00 will be billed to your insurance**

Prior Fitting: **\$140.00 will be billed to your insurance**

I understand that I am fully responsible for the payment of any any all charges if these charges are not covered by the assigned benefits. I understand I may pay these fees at the time of service.

Patient/Guardian Signature

Date

DILATION

I understand that the physician may be using dilation drops for my eye exam. An eye exam cannot be complete without dilation. I am aware that my vision may be blurred for several hours which varies from person to person. Bright lights also may be bothersome after my examination. **I acknowledge and understand the usage of dilation drops for my exam.**

Patient/Guardian Signature

Date

Consent for Verbal Release of Information

Plainfield Ophthalmology has my permission to leave information regarding my medical condition on my:

Home Answering Machine # _____

Cell Phone # _____

Work Voice Mail # _____

Plainfield Ophthalmology has my permission to communicate my health information to the following individuals:

Name _____ Relation to patient _____ Phone # _____

Name _____ Relation to patient _____ Phone # _____

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice to Plainfield Ophthalmology of my desire to do so. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Patient/Guardian Signature

Date

APPOINTMENT REMINDERS

All appointment reminders will be sent by email only. **You are responsible to remember and keep your appointment regardless if you receive a reminder or not.** If you would like the option of also receiving an automated voice reminder and/or text message please fill out the information below.

I consent to Plainfield Ophthalmology to contact me by **Automated Voice Reminder** for the purpose of appointment reminders. I understand that this consent to receive voice reminders will apply to all future appointments unless I request a change in writing. I agree to advise the practice if my phone number changes or is no longer in service.

Patient/Guardian Signature

Date

Phone Number

I consent to Plainfield Ophthalmology to contact me by **Text Message** for the purpose of appointment reminders. I understand that Plainfield Ophthalmology does not charge for this service but standard text messaging rates may apply as provided in your wireless plan, please contact your carrier for details. This consent will apply to all future appointments unless I request a change in writing. I agree to advise the practice if my phone number changes or is no longer in service.

Patient/Guardian Signature

Date

Phone Number

