Insurance Information

Vision Insurance _____
Subscriber's Name _____
Subscriber's DOB ____/____/_____
Patient's Relationship to Insured:
☐ self ☐ child ☐ spouse
Subscriber's ID _____

Medical Insurance (Primary) _____
Subscriber's Name_____
Subscriber's DOB ____/____/_____
Patient's Relationship to Insured:
☐ self ☐ child ☐ spouse
Subscriber's ID _____

Please read, initial and sign the following **FINANCIAL POLICY**. If you have any questions please feel free to ask us.

Patients are expected to pay in full at the time services are rendered. After 45 days, balances are considered delinquent, and are subject to a fee of $15 for every statement we send you. Checks that fail to clear are subject to a $50 fee. Please notify us with at least 24 hours advance notice should you need to change your appointment. Missed appointments will be subject to a $40 fee. _____ ***(Please Initial)***

Please let us know your **vision** and **medical** insurance **prior** to your visit and if you wish to use it. Although we participate in many insurances, this is not a guarantee of benefits and it is your responsibility to know your insurance benefits and eligibility. Please provide us with your current, valid insurance card(s) as well as any complete referrals or forms required by your insurance. Medical conditions may necessitate additional medical tests beyond the scope of your vision coverage or initial referral form. In such cases, it is important that you communicate with our office about your medical insurance and any referrals you may need. If you notify us of your desire to use insurance *after* services are rendered, you may request an itemized receipt to submit to your insurance company for reimbursement directly from your plan. However, be aware that your insurance company may only send you a partial reimbursement or nothing at all, depending on your insurance company's policies, contractual rates and procedures. It is every patient's responsibility to know their insurance plan, referrals and/or certification procedures needed for their insurance plan. _____ ***(Please Initial)***

Contact lens services incur additional fees that your insurance may not cover. The initial contact lens fitting period includes 2 follow-up visits within 60 days of the initial fitting or otherwise as indicated by your insurance. Should the fitting period elapse before finalizing your contact lens prescription, a new fitting fee applies. _____ ***(Please Initial)***

The **Health Insurance Portability & Accountability Act of 1996 ("HIPAA")** is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. As required by "HIPAA", we have prepared a **"Notice of Privacy Practices Policy"**. This explains how we are required to maintain the privacy of your health information and how we may use and disclose your health information. A copy of this policy is available to you at your request.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Crystal Eyecare, Notice of Privacy Practices.

Date_____ Patient Name_____ Signature_____

The Doctors or staff may discuss my situation or condition with the following individual(s):

Name_____ Relationship_____

Name_____ Relationship_____