DATE _____

clearvision
OPHTHALMOLOGY, PLLC

PATIENT DEMOGRAPHIC UPDATE: (Established Patient Only)

Patient Name First_____ MI_____ Last _____SS#_____
DOB _____ Sex □ M □ F Parent/ Legal Guardian Name if patient is a minor _____ DOB _____
Address _____Apt # _____ City_____ State_____ Zip _____
Phone: Home_____ Cell_____Work_____
E-Mail_____ Other _____

EMERGENCY CONTACT INFORMATION

Name _____Relationship to Patient _____
Phone: Home_____ Cell_____ Work_____ Email _____

INSURANCE INFORMATION (Please upload your Current Insurance Card and Driver's License through our secure web portal)

PRIMARY INSURANCE:

Patient Relationship to Insured: □ Self □ Spouse □ Child □ Other_____
Primary Insurance_____ Member ID _____

SECONDARY INSURANCE:

Secondary Insurance _____Member ID _____

CHIEF COMPLAINT

What is the main or primary issue with your eye(s) and or vision? _____
When did you first notice symptoms? _____
Please provide necessary details regarding your condition(s)_____
_____
_____

PHARMACY / MEDICATION REFILL

Refill requests made outside of your scheduled appointment may take 48-72 hours to process. Please allow sufficient time for Clear Vision Ophthalmology PLLC to process your refill request.

Initials _____ X

Pharmacy Name_____ Pharmacy Tele# _____Pharmacy Fax# _____
Address or Cross Street_____

ALLERGIES: ◯ **NO KNOWN Allergies:** ◯ **YES (please specify)**

Antibiotics:	Aspirin:	Codeine:	Latex:	Shellfish:	Other/Foods/ Explain:

Other Known Allergy / Reaction	Other Known Allergy / Reaction
/	/

In order to serve you better, please provide current medications.

List ALL Current Medications and Supplements you are taking (if you have a printed list, please provide)

Name	Dosage	Frequency

PRACTICE PRIVACY POLICY

Clear Vision Ophthalmology PLLC will protect your health information based on the guidelines set forth by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). By signing below, you acknowledge that Clear Vision Ophthalmology PLLC, has provided you a copy of its Practice Privacy Policy, which explains how we may use and/or disclose your health information.

Patient Name (Print): _____ X **Patient's Legal Representative Name (if applicable):**_____ X

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Patient/ Patient's Legal Representative Signature: _____ X Date: _____ X

ASSIGNMENT OF BENEFIT AGREEMENT

I hereby authorize my insurance company, including Medicare, if I am a Medicare Beneficiary, to make payments to Clear Vision Ophthalmology PLLC for medical or surgical services or items rendered to me or my dependent by Clear Vision Ophthalmology PLLC. Should my insurance carrier deny Clear Vision Ophthalmology PLLC payment, I understand that I am financially responsible for the charges. I authorize Clear Vision Ophthalmology PLLC to release any and all of my records to my insurer, or any other third-party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance and health information. I permit a copy of this authorization to be used in place of the original.

Clear Vision Ophthalmology PLLC **does not accept vision insurance**. The patient or patient's legal representatives are responsible for fees of any services not covered by your medical insurance.

Patient Name (Print): _____ X Patient's Legal Representative Name (if applicable):_____ X

Patient/ Patient's Legal Representative Signature: _____ X Date: _____ X

FINANCIAL AND PAYMENT GUIDELINES

For your convenience we accept cash, check, debit card and credit card payments. Any credit card payment will be assessed a 3% convenience fee which is a fee charged by the credit card processing company and is not a charge from Clear Vision Ophthalmology PLLC.

REFERRALS

If you require a referral from your primary care physician, you must have it prior to seeing the doctor or you will be responsible for payment. we will submit your claims using the insurance information given on the date of service. you must notify the front desk if you do not have your referral

CANCELLATION POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not **CALL OUR OFFICE TO CANCEL AN APPOINTMENT**, you may be preventing another patient from getting the much needed treatment from our office. Please understand that we set aside appointment times for each patient in which we do not double book our patients. Please be informed that starting January 1, 2018, **there will be a $25.00 fee for 'NO SHOW' or 'LATE CANCELLATION' appointments**. This fee must be paid in full before you are seen again. This fee is not covered by your insurance company. We apologize for any inconvenience but hope that you understand that we want the best care for all our patients.

REFRACTION FEES

What is a refraction? Refraction is a test done to determine the refractive error of your eyes, or the need for corrective glasses and/or contact lenses.

When do I have to pay for a refraction?

Refraction (CPT code 92015) is a non-covered service by Medicare. As a result, your healthcare provider is required by CMS (the department to the federal government that controls Medicare) to charge for this service. Most insurance plans follow Medicare's rules. All these plans consider **refraction a "vision" service, and not a "medical" service**.

How much do I have to pay? You will only be charged a refraction fee if you receive a prescription for glasses or contact lenses. Our office charges a **refractions fee of $35.00** and is **collected at the time of service**. This amount is In addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will refund you accordingly.

If you are a Medicare patient, you will be charged for this service, since it is not covered by Medicare. If you have a non-Medicare insurance plan, the refraction policy still applies. We will bill your insurance, and if payment is approved, we will refund you accordingly.

Knowing this, I (*the patient or legal representative*) have instructed the doctor to proceed with the services. If insurance decides to reduce or even deny the fee or services, I agree to pay the doctor's fee in full.

Suggestions When Filling Your Prescription Since refraction is an inexact art in which errors may arise at any step, including from the patient, the doctor, and the optician making the eyeglasses, we suggest the following:

1. Fill your prescription at an establishment that will give you a warranty. At the very least, choose an optical that agrees to make at least one adjustment at no charge to you. If you are uncomfortable with the new prescription for whatever reason, this will enable us to make changes as necessary at no cost to you.

2. Start with purchasing only one pair of new glasses with the new prescription to ensure you are happy with your vision before purchasing new pairs.

3. Please address any legibility issues regarding the written prescription with the prescribing doctor prior to filling the prescription.

4. Change as few parameters like lens size and shape, lens company/brand (especially with progressive add spectacles), as possible, with your new glasses to minimize the risk of being uncomfortable with newly prescribed glasses.

I. Non-Medically Necessary Contact Lens Fitting please be aware that most medical insurance do not cover the portion of the eye examination to evaluate you for elective contact lenses. This part of the examination requires a separate evaluation in addition to the medical examination. Contact lenses are medical or cosmetic devices placed on a vital organ in your body. An improper fit may cause a host of problems including infection, permanent scarring, new growth of blood vessels, contact lens rejection and ultimately decreased vision. Based on FDA regulation, contact lens prescriptions are only valid for 1 YEAR.

An annual contact lens evaluation is required. If you are also being seen for an ocular complaint that requires a medical examination, your insurance will be billed for the medical portion.

II. What if my glasses or contact lenses do not fit well? Our physician will re-evaluate you at no charge within 45 days of your initial refraction to change your prescription if necessary. However, our office does not pay for revision of glasses in which good faith efforts were made in measuring and writing the prescription.

I understand that refraction and contact lens examination are not included in my eye exam and there will be an additional fee. Refraction and contact lens fitting fees are non-refundable, only if your insurance carrier denies coverage for service. Any changes that need to be made to your prescription must be made within 45 days of your examination.

I have been fully informed and accept full responsibility to pay.

Patient Name (print) _____ Patient's Legal Representative Name (if applicable) _____

Relationship of Legal Representative to Patient (if applicable) _____

Patient / Patient's Legal Representative Signature _____ **Date**_____