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New Patient Registration Form

*DEMOGRAPHICS

First Name: _____ MI _____ Last Name: _____ DOB: _____

Parent/Guardian Name (if patient is minor): _____

Gender: □ M □ F Race: □ Caucasian □ Black/African American □ Asian □ Hispanic/Latino □ Native American □ Other

Home Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Email: _____

*EMERGENCY CONTACT

Full Name: _____ Relationship: _____ Phone: _____

*PRIMARY CARE PHYSICIAN

PCP Name: _____ Phone: _____

*PHARMACY

Name: _____ Phone: _____ Address: _____

ALLERGIES

○ No Known Allergies ○ Yes: _____ Reaction: _____

INSURANCE

□ **Self** □ **Spouse** □ **Child**

Primary Insurance: _____ Member ID: _____

Secondary Insurance: _____ Member ID: _____

FINANCIALLY RESPONSIBLE PARTY (INSURED)

○ Same as Patient Information (If different, please complete section below)

First Name: _____ MI _____ Last Name: _____ DOB: _____

□ **Spouse** □ **Parent** □ **Guardian**

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Phone: _____ Address: _____ Email: _____

EYE MEDICAL HISTORY ☐ NONE ☐ NONE

Personal	YES	NO	Family	YES	NO
Glaucoma	○	○	Glaucoma	○	○
Cataract	○	○	Cataract	○	○
Corrective Laser Eye Surgery	○	○	Corrective Laser Eye Surgery	○	○
Crossed Eyes (Strabismus)	○	○	Crossed Eyes (Strabismus)	○	○
Droopy Eyelids	○	○	Droopy Eyelids	○	○
Dry Eye	○	○	Dry Eye	○	○
Eye Inflammation	○	○	Eye Inflammation	○	○
Eye Injury	○	○	Eye Injury	○	○
Lazy Eye (Amblyopia)	○	○	Lazy Eye (Amblyopia)	○	○
Macular Degeneration	○	○	Macular Degeneration	○	○
Retinal Detachment	○	○	Retinal Detachment	○	○
Tearing (Epiphora)	○	○	Tearing (Epiphora)	○	○
Thyroid Eye Disease (Graves' Disease)	○	○	Thyroid Eye Disease (Graves' Disease)	○	○
Other	○	○	Other	○	○

EYE SURGERICAL HISTORY

Surgery	Date Performed	Location	Surgeon

GENERAL MEDICAL HISTORY ☐ NONE ☐ NONE

Personal	YES	NO	Family	YES	NO
Asthma	○	○	Asthma	○	○
Arthritis	○	○	Arthritis	○	○
Autoimmune Disease	○	○	Autoimmune Disease	○	○
Blood Pressure Disorder (Hypertension)	○	○	Blood Pressure Disorder (Hypertension)	○	○
Cancer	○	○	Cancer	○	○
Diabetes	○	○	Diabetes	○	○
Headaches/Migraine	○	○	Headaches/Migraine	○	○
Hepatitis	○	○	Hepatitis	○	○
High Cholesterol	○	○	High Cholesterol	○	○
HIV/AIDS	○	○	HIV/AIDS	○	○
Seizure/Epilepsy	○	○	Seizure/Epilepsy	○	○
Stroke	○	○	Stroke	○	○

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Thyroid Disease	○	○	**Thyroid Disease**	○	○
Other	○	○	**Other**	○	○

GENERAL SURGICAL HISTORY

Surgery	Date Performed	Location	Surgeon

MEDICATIONS

***List ALL current medications and supplements (if you have a printed list, please provide)** ☐ **NO MEDICATIONS**

Medication	Dosage	Frequency

SOCIAL HISTORY

	YES	NO
Alcohol use?	○	○
Recreational drug use?	○	○
Have you ever smoked?	○	○
Are you a current smoker?	○	○
Do you have night vision difficulty?	○	○
Do you have difficulty reading street signs?	○	○
Do you have difficulty reading fine print?	○	○

*EYECARE INFORMATION

	YES	NO
Do you wear glasses?	○	○
Do you wear contact lenses?	○	○
Have you worn contact lenses before?	○	○
Do you want to be examined for:		
• Glasses	○	○
• Contact Lenses	○	○

What is the main issue with your eyes or vision?

_____

When did you first notice symptoms?

_____

What is the reason for your visit?

□ Comprehensive, Dilated Eye Exam □ Cataract Evaluation □ Diabetic Eye Exam □ Dry Eye Evaluation

□ Eye Injury / Infection □ Failed Vision Screening □ Glaucoma Evaluation □ Visual Disturbance

□ Other:

_____

_____

TERMS & CONDITIONS

PATIENT COMMUNICATION CONSENT

By signing this form, you acknowledge and consent to receive communications from our office via SMS, which may include appointment reminders, billing information, and other general updates. Please note that standard SMS is not encrypted and may not be secure for sensitive health information. For your privacy and security, we also offer a secure online portal at www.cveye.com where you can communicate with us about your health concerns in a more confidential manner. Additionally, should you need to send encrypted documents, we provide a secure link at www.cveye.com/upload-documents for uploading sensitive information.

***Print Name:** _____

***Patient or Patient's Legal Representative Signature:** _____ ***Date:** _____

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.

***Print Name:** _____

***Patient or Patient's Legal Representative Signature:** _____ ***Date:** _____

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

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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 the patient's legal representative are responsible for fees of any services not covered by your medical insurance.

***Print Name:** _____

***Patient or Patient's Legal Representative Signature:** _____ ***Date:** _____

FINANCIAL AND PAYMENT GUIDELINES

I. Financial Responsibility Agreement

By signing this form, I acknowledge and agree to the following:

1. **Insurance**
   I am responsible for providing accurate and up-to-date insurance information. While my insurance may cover a portion of my care, I understand and accept full personal responsibility for all charges not paid by my insurer, including but not limited to co-pays, deductibles, coinsurance, and non-covered services. I agree to pay these balances in a timely manner, regardless of the reason for non-payment by my insurance provider.
2. **Non-Covered Services**
   I understand that some or all services provided may not be covered by insurance, and I accept full responsibility for these charges.
3. **Authorization to Bill and Release Information**
   I authorize the release of medical and financial information necessary to process insurance claims and facilitate direct payment to the provider for services rendered.
4. **Payment Terms**
   Clear Vision Ophthalmology PLLC only accepts credit cards for payment plans. Payment is due at the time services are rendered unless prior arrangements are made. Payments must be made on or before the due date of each month.
5. **Failed Payments, Delinquency, and Legal Action**
   In the event of non-payment, default, or failure to meet agreed payment obligations, the following terms will apply:
   a. Returned checks are subject to a $35 service fee.
   b. Each declined or failed payment, or reprocessing attempt due to an invalid method or insufficient funds, will incur a $10 processing fee.
   c. If I do not provide a valid updated form of payment within 48 hours of a failed charge attempt, the entire remaining balance becomes immediately due in full.
   d. The account may be automatically forwarded to collections and/or initiate legal action to recover the outstanding balance without additional notice, and any payment plan in place will be considered terminated.
   e. If a court judgment is obtained, remedies may include wage garnishment, bank levies, or property liens, as allowed under New York State law.
   f. I am liable for court costs and reasonable attorney's fees, and any fees imposed by third-party collection agencies.
   g. Interest at an annual rate of 12% will be calculated monthly and applied to outstanding balances.
   h. A $500 administrative fee may be applied to cover recovery costs.

II. Payment Plan Agreement

Total Balance: _____
Down Payment: _____
Remaining Balance: _____

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Monthly Installment: _____
Due Date Each Month:_____
Number of Payments: _____
Final Due Date: _____

I understand that any breach, including missed payments or invalid payment methods, will result in immediate full balance due and may result in termination of this plan. Failure to meet payment obligations may result in collections, legal action, and additional fees as outlined above.

III. Credit Card Authorization
I authorize Clear Vision Ophthalmology PLLC to charge my credit card for the payment of medical services and/or for recurring payment plans on a recurring basis until the full balance including all associated fees has been paid. New fees may arise due to delay/failure in payment, and/or failure to comply with this agreement will be subject to the same terms as the original balance outlined in this agreement. There will be a 3% convenience fee for all credit card transactions, and I acknowledge that this fee reflects actual transaction processing costs and not a surcharge. I understand that my information will be securely stored and used only for authorized transactions related to the medical services rendered.

Cardholder Information
Cardholder Name: _____
Billing Address: _____
_____
City: _____ State: _____ ZIP: _____
Phone Number: _____

Credit Card Details
Card Type: □ Visa □ Mastercard □ Amex □ Discover
Credit Card Number:
Expiration Date: (MM/YY): _____
CVV: _____

Payment Compliance
I agree to:

- Keep a valid and funded payment method on file at all times.
- Provide an updated card within 48 hours if the current card is declined.
- Understand that failure to comply will result in immediate full balance due, termination of the plan, account being forwarded to collections, and possible legal action as stated above.

Cardholder Signature: _____ Date: _____

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**.

***FINANCIAL POLICIES: STANDARD OPERATING PROCEDURE (SOP)

The purpose of this policy is to establish a standardized process for offering payment plans to patients who do not have a credit card (CC) on file, while ensuring the organization secures appropriate financial responsibility prior to initiating any payment arrangements. This SOP applies to all patients requesting a payment plan for outstanding balances, particularly those intending to pay by **cash or check** and do not have a **credit card (CC)** on file.

Payment plans can only be approved under the following conditions, **NO EXCEPTIONS**:

1. **Credit Card Requirement**
   a. A valid **credit card must be on file** to initiate and maintain a payment plan.
   b. The card is used to secure the plan, even if payments are made by other means (e.g., check or cash).
2. **Alternative: Debit Card**
   a. If a credit card is not available, a **debit card** linked to a checking account is acceptable.
   b. It is expected that patients with a checking account have access to a debit card.
3. **Third-Party Responsibility**

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   a. If the patient is **unwilling or unable** to provide a credit/debit card:
      i. A third party (e.g., family member, friend, guarantor) must assume financial responsibility.
      ii. The third party must provide **valid CC details** before the agreement is processed.
4. **No CC or Financial Assumption**
   a. **If no credit/debit card is provided**, and **no third party assumes responsibility**, the patient **must pay the full balance immediately.**
   b. A payment plan **cannot be created** under these circumstances.

***** I have been fully informed and accept full responsibility to pay** ☐

***Print Name:** _____

***Patient or Patient's Legal Representative Signature:** _____ ***Date:** _____

***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. **ALL appointments are to be cancelled 2 business days in advance as per office policy.**

There is a $25.00 fee for SAME DAY/LATE CANCELLATION/NO SHOW of appointments. There is a $75.00 fee for SAME DAY/LATE CANCELLATION/NO SHOW of Saturday appointments. There will also be a $25 fee for any patient who chooses to leave their appointment before being seen by any doctor on duty.

SAME DAY CANCELLATION (SDC): Calling our office on your appointment date to cancel your appointment.

LATE CANCELLATION (LC): Calling our office 1 day before your appointment date to cancel your appointment.

NO SHOW: Not showing up to your appointment 30 minutes after your appointment scheduled time.

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.

REFERRAL GUIDELINES

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. It is your responsibility to know if your specific plan requires a referral from your primary care provider.

REFERRAL WAIVER

If you wish to visit the ophthalmologist before obtaining a referral from your primary care physician (PCP), your insurance will not cover the treatment by the specialist. You may be responsible for all charges for this visit. Because we do not have a referral on file for your visit today, please sign this form:

"Clear Vision Ophthalmology PLLC has agreed to see me today without a referral from my PCP. If I do not provide a valid referral within three (3) business days of my visit, I agree to pay for my treatment in full. I have provided a credit or debit card number below to be billed in the event that my PCP does not authorize my insurance company with a referral to pay for my visit. If your insurance does not requires a referral to be seen kindly skip this section."

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Name on Card: _____ **Billing Address:** _____

Card Number: _____ **Exp Date:** _____ **CVV:** _____

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 refraction 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 insurance plan pay us for the refraction, we will not charge you.** 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 don't 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

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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.**

***Print Name:** _____

***Patient or Patient's Legal Representative Signature:** _____ ***Date:** _____