# Brandon Eye Associates

NAME:_____
Last First MI

DATE OF BIRTH:_____ SOC. SEC. #: _____

HOME TELEPHONE #:_____CELL PHONE #:_____

ADDRESS:_____
City State Zip

MARITAL STATUS: M_____ S_____ D_____ W_____ GENDER: (Circle One) Male / Female

RACE (check all that apply): ☐American Indian or Alaska Native ☐Asian ☐Black or African American
☐Native Hawaiian or Other Pacific Islander ☐White ☐ More than one race

ETHNICITY : ☐Hispanic or Latino ☐Not Hispanic or Latino PREFERED LANGUAGE:_____

PATIENT (or parent's) EMPLOYER: _____WORK #:_____

OCCUPATION:_____ E-MAIL ADDRESS:_____

PRIMARY CARE PHYSICIAN'S NAME:_____

OPTOMETRIST'S NAME: _____ ADDRESS:_____

WHICH DOCTOR REFERRED YOU TO OUR OFFICE?: _____

**PERSON TO NOTIFY IN CASE OF EMERGENCY:**

NAME: _____ HOME #:_____ WORK #: _____

RELATIONSHIP TO PATIENT:_____

**INSURANCE INFORMATION:**
*WE WILL BILL A MAXIMUM OF 2 MEDICAL **OR** 1 VISION INSURANCE PER DATE OF SERVICE.*

**PRIMARY MEDICAL INSURANCE COMPANY NAME:**_____

POLICYHOLDER'S NAME: _____Group#: _____ID#:_____

POLICYHOLDER'S SOC. SEC #:_____ DATE OF BIRTH:_____(if other than patient)

**SECONDARY MEDICAL INSURANCE COMPANY NAME:** _____

POLICYHOLDER'S NAME: _____Group#: _____ID#:_____

POLICYHOLDER'S SOC. SEC #:_____ DATE OF BIRTH:_____(if other than patient)

**VISION INSURANCE COMPANY NAME:** _____

POLICYHOLDER'S NAME: _____Group#: _____ID#:_____

POLICYHOLDER'S SOC. SEC #:_____ DATE OF BIRTH:_____(if other than patient)

I hereby assign all medical and/or surgical benefits, including major medical benefits, Medicare, Private and group insurance or other health care plan to Brandon Eye Associates. A photocopy of this assignment is as valid as an original, and revocable by me only in writing. I hereby authorize said assignees to release all information to secure payment. I hereby authorize release of all medical information necessary for treatment and to all healthcare providers involved in my care. I accept ultimate financial responsibility for account incurred by the above named patient at Brandon Eye Associates. I understand that nonpayment by a third party carrier does not relieve me of this responsibility.

_____

Patient Signature Date

PARENT (Legal Guardian):_____
Name Soc. Sec. # D.O.B

# BRANDON EYE ASSOCIATES

**PATIENT NAME:** _____ **Pt #:**_____

**Vision Eye Exam (Routine Visit):**
These examinations determine if vision can be improved with glasses or contact lenses and screen for eye diseases.

**Medical Eye Exam:**
These are examinations for diagnosis and treatment of eye diseases. If glasses or contact lenses cannot improve vision, often the cause is related to an underlying medical eye condition.

CIRCLE THE TYPE OF EXAM YOU ARE HAVING TODAY:

**Vision / Medical** _____ _____
**Patient Signature** **Date**

**Refraction:**
Refraction is the optical determination of the best possible eye vision. It is needed to determine if any medical, optical, or surgical treatment may be indicated. It is **NOT** a covered service by most insurance plans.

Do you want an eyeglasses and / or contact lens prescription today? **YES NO**
Do you want a copy of your eyeglasses and / or contact lens prescription today? **YES NO**
Do you want to change the lens and / or frame of your prescription today? **YES NO**

If you answered yes to any of the above questions, you need a refraction. **Our office fee for refraction is $40.00** , is collected at the time of service, and is in addition to any co-payment.

Revised: 01/27/2023

# BRANDON EYE ASSOCIATES

## PATIENT CONSENT AND AUTHORIZATION FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. A complete copy of Brandon Eye Associates' Notice of Privacy Practices is published in our waiting room and on our website. You may also request a printed copy at any time. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Brandon Eye Associates, Inc. provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- Brandon Eye Associates, Inc. has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- Brandon Eye Associates, Inc. reserves the right to change the Notice of Privacy Policies. If we change our Notice, you may obtain a revised copy by contacting our office.
- The patient has the right to restrict the uses of their information but Brandon Eye Associates, Inc. does not have to agree to those restrictions.
- The patient may revoke this Consent in writing any time and all future disclosures will then cease.
- Brandon Eye Associates, Inc. may condition treatment upon the execution of this Consent.

On occasion, the patient and Brandon Eye Associates, Inc. may want to use or disclose PHI for a specific purpose other than treatment, payment, and health care operations. *Anticipated use or disclosure of information about you for which this authorization is required includes but is not limited to: ordering medications at a pharmacy, authorizing refills to a pharmacy, ordering of eyeglass frames, lens, contact lens, lab tests, x-rays, physicians the patient is being referred , outpatient surgery, and third party payers.*

Individuals who may use or disclose this information: *Front and back office staff, physicians, Practice Administrator, Optical Department, Medical Records personnel, and Compliance Officer.*
Individuals who may receive and use the disclosed information: *Pharmacies, optical labs, contact lens vendors, hospitals, medical labs, insurance companies, other doctor's office staff you are being referred.*

Expiration date of this authorization: *One year from date of signing the Authorization form.*

This Authorization was signed by: _____
Signed Name – Patient or Representative
Would you like a copy? ☐ Yes ☐ No
☐ Copy given

Relationship to Patient (if other than patient): _____

In front of: _____ Date: _____
Signed Name – Brandon Eye Associates

Brandon Eye Associates complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

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# AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO INDIVIDUALS

_____ DOB:_____ SS#_____

Name of Patient

I understand that BRANDON EYE ASSOCIATES (BEA), from time-to-time, may be requested to disclose my protected health information (PHI) with members of my family or a close friend. Therefore, I authorize BEA to disclose my PHI for the following purposes:

- □ Make an appointment for me
- □ Cancel an appointment for me
- □ Obtain test or lab results on my behalf
- □ Discuss my current health condition or symptoms
- □ Pick-up written prescriptions or pharmaceutical samples on my behalf
- □ Other:
- □ All the above

with the following individuals:

| **Person's Name** | **Relationship to Patient** | **Phone Number** |
|---|---|---|
| | | |
| | | |
| | | |

I understand that if information is requested via telephone, the caller will be asked to identify me by providing (a) my social security number and my date of birth as shown on BEA's records, and (b) the caller's full name shown above. If the request is made in person, the individual will be required to provide proper identification, including a picture ID.

I understand that in order to add or delete designated people from this list, I must notify BEA in writing. I also understand that I may revoke this authorization in its entirety by providing written notification to BEA, or signing a Revocation of Authorization for Disclosure of Health Information form provided by BEA.

**I understand that this authorization excludes BEA from providing copies of my medical records to the above individuals without the proper release form.**

_____ _____

Signature of Patient or Personal Representative Date Signed

_____ _____

Name of Patient or Personal Representative ***Updated – Initial & Date***

_____ _____

Personal Representative Relation to Patient ***Updated – Initial & Date***

# Brandon Eye Associates

## OFFICE POLICIES

Co-Pays

It is our policy to collect your insurance co-pay at the time of your appointment. This simplifies the office process and ensures the financial obligation is met at the time of service.

Co-Insurance/Deductibles

Every effort is made to fairly estimate the co-insurance or deductible owed based on the nature of the visit. It is our policy to collect these payments at the time of service.

Billing

As a courtesy, Brandon Eye Associates bills your health insurance provider on your behalf, with the following guidelines/exceptions:

- Insurance card: It is critical that the most current insurance card is brought to every appointment. We must have the correct information at the time of service. An insurance card is similar to a credit card – the information must be current and valid in order for it to be used.
- Auto Insurance: We do not bill auto insurance for visits and medical care related to an auto accident. Payment will be required at the time of service, and we will provide the paperwork needed for you to submit to the auto insurance provider for reimbursement.

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network with your insurance company and your insurance company pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Referrals and Preauthorizations

Certain health insurances (HMO, POS, etc.) require that you obtain a referral or prior authorization from your Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain referral and/or preauthorization may result in a lower or no payment from the insurance company and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

Patient Initials:_____

# Brandon Eye Associates

Refractions

During the course of your treatment, you may need to have a refraction. A refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses or a change in vision. It is an essential part of an eye examination and necessary to write a prescription for glasses or contact lenses as well as a diagnostic tool for your physician. It is NOT a covered service by Medicare or most insurance plans. These plans consider this a "vision" service and not a "medical" service.

Our office fee for a refraction is $40.00 and is collected at the time of service in addition to any co-payment your plan might require.

Fees for Medical Copies/Forms/Reports

-$1.00 per page for copies up to 25 pages...$0.25 per page for each additional

-$25.00 minimum for all forms (FMLA, Disability Forms, Special Forms)

-Requests for medical records/forms require a minimum of 7 business days

Appointment Policy

A minimum of 24 hours' notice is required to reschedule or cancel an appointment. If you are late for an appointment, our staff will check with the physician you are scheduled with to see if you can still be seen. If you are late, it is possible you will either have a longer wait time to get back to see the doctor or it may be necessary to reschedule your appointment.

Telephone Messages

Telephone messages have a 48 hour (2 business day) turn around.

Prescription Refills

Prescription refills require a 5-business day notice.

ALL PAYMENTS ARE DUE AT TIME OF SERVICE.

| _____ | _____ | _____ |
|---|---|---|
| Patient Name | Patient Signature | Date |