

# Lake Lazer Eye Center

SPECIALIZING IN DISEASES & SURGERY OF THE EYE

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

DOB \_\_\_\_\_ SSN \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status: M S W D

Race: African American/Black American Indian/Alaskan Native Caucasian/White Native Hawaiian/Pacific Islander Other Decline to Answer

Ethnicity: Hispanic/Latino Non Hispanic/Latino Decline to Answer

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Employment Status: Active Duty Military Full-Time Part-Time Retired Self-Employed Student Full-Time Student Part-Time Unemployed

Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_

Family Physician \_\_\_\_\_ Physician Phone \_\_\_\_\_

How did you hear about us?/Referred by \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

## **CURRENT MEDICATIONS (include regularly used OTC medications)**

## **PRIMARY INSURANCE - Please provide insurance card(s) with this completed form**

Policy Holder's Name \_\_\_\_\_ Policy Holder's DOB \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insured's ID# \_\_\_\_\_

Policy Group ID# \_\_\_\_\_ SSN \_\_\_\_\_

Policy Holder's Relationship to Patient \_\_\_\_\_ Do you have Medicare Coverage? \_\_\_\_\_

## **SECONDARY INSURANCE**

Policy Holder's Name \_\_\_\_\_ Policy Holder's DOB \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insured's ID# \_\_\_\_\_

Policy Group ID# \_\_\_\_\_ SSN \_\_\_\_\_

Policy Holder's Relationship to Patient \_\_\_\_\_ Do you have Medicare Coverage? \_\_\_\_\_

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**Financial Agreement:**

We participate in many different insurance plans. We will file your insurance claims for the companies with whom we are contracted. You will be responsible for any co-payments and/or deductibles at the time services are rendered. For some insurance we accept assignment of benefits but in all cases we require that the guarantor, the person who is financially responsible, is personally liable for all balances not covered by insurance. It is our responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance companies. You will be responsible for co-payment, deductibles, out-of-network amounts or any portion your insurance company indicates is your responsibility. Payment for co-pays and/or deductibles are expected at the time of service. If this fee is not covered by insurance it will be your responsibility.

**Assignment of Insurance Benefits:**

I hereby authorize direct payment to Lake Lazer Eye Center of any insurance or health benefits otherwise payable to or on behalf of the patient for examination, treatment and/or devices at the rate not to exceed Lake Lazer Eye Center's usual charges. I understand that verification of insurance coverage obtained over the phone or online is estimated and does not guarantee payment and that insurance coverage is a relationship between the patient and his/her insurance company(s). I agree to accept financial responsibility for any charges for goods and services rendered to the patient that are not paid by insurance or health benefit plan pursuant to this assignment of benefits.

**Release of Information:**

I hereby authorize Lake Lazer Eye Center to release any medical information about the patient necessary to determine liability for payment and to process any claim for examination, treatment and/or devices received by the patient. I also authorize Lake Lazer Eye Center to release the medical records or the patient to the patient's referring physician or family physician indicated on this form.

**Financial Responsibility Agreement by Other than Patient's Legal Representative:**

I agree to accept financial responsibility for the goods and services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Benefits, and Release of Information provisions above.

**HIPAA Acknowledgement:**

By signing below, I acknowledge that I received a copy of Lake Lazer Eye Center's Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted on the website and that any revised Notice of Privacy Practices will be made available.

**I HAVE READ AND AGREE TO THE TERMS ABOVE:**

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Patient or Legal Representative (print)

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Patient or Legal Representative

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Date

I, \_\_\_\_\_ give Lake Lazer Eye Center permission to leave telephone messages. This will remain in effect until you rescind it in writing.

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## NOTICE TO ALL PATIENTS

Our office appointment policy is listed below. We thank you for your cooperation.

1. We request 48 hours notice for cancellation or rescheduling of an appointment. This allows us to provide care to other patients waiting for an appointment. We will give you a reminder call at least 2 days prior to your appointment.
2. **Appointments that are missed, cancelled or rescheduled with less than 48 hours prior to the date and time of the appointment are subject to a \$25 charge.**
3. **APPOINTMENTS FOR PROCEDURES (i.e. LASIK, LID SURGERY, AMNIOTIC MEMBRANE OR ANY OTHER SURGERY) THAT ARE MISSED, CANCELLED OR RESCHEDULED LESS THAN 5 BUSINESS DAYS PRIOR TO THE DATE AND TIME OF THE APPOINTMENT ARE SUBJECT TO A \$250 FEE.**
4. If your insurance requires a referral, it is your responsibility to provide it at the time of your appointment. If the referral is not available, you will need to reschedule or be responsible for the payment of charges.
5. While visiting our office, we ask that you refrain from using your cell phone as it affects our equipment.
6. Please bring an updated medication list with you to your appointment.
7. We require that all patients show photo ID and insurance cards at each visit. This is to prevent insurance fraud.
8. Please bring sunglasses and have a driver available when you schedule your dilated eye exam. If you are being followed for contact lens issues, please bring them with you.
9. Prescriptions are sent electronically. Please bring in your preferred pharmacy information with you.
10. Lake Lazer Eye Center performs eye exams and procedures *that fall under the **medical** insurance*
11. *category*. We also offer exams for glasses and contact lenses which fall under the *umbrella of **vision** insurance*. Vision insurance does **NOT** cover an exam if you are having problems that are related to an eye disease – this is only covered under medical insurance just as if you had a medical problem with any other part of the body. Conversely, your medical insurance will not cover a routine exam for eyeglasses/contact lenses unless you have a vision rider.

Patient Name: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## **RETURN POLICY FOR EYEGLASSES & CONTACT LENSES**

**All sales of prescription and non-prescription contact lenses, eyeglasses and sunglasses are final. Orders take 7 to 10 business days to arrive.**

If, however, there are any discrepancies between the Doctor's prescription and the lenses manufactured by the lab, or between the Doctor's prescription and the actual prescription, any adjustments to the prescription lenses are included at no charge within 60 days.

All orders require at least 50% deposit.

Adjustments for glasses and minor repairs are provided free of charge.

**Professional services are nonrefundable.**

## **POLICY FOR PICKING UP EYEGLASSES & CONTACT LENSES**

All eyeglasses and contact lenses that have been prescribed, fitted, and purchased by the patient will be kept in the office for a total of one year from the date of purchase. If the patient does not pick up his/her eyeglasses or contact lenses within that year, they shall, by default, become the property of LLEC, and we will no longer be responsible for those eyeglasses or contact lenses.

**I have read, understood, and shall abide by all aspects of the policies explained to me above. It has been made known to me that if any or all parts of the above policies are not fully understood by me, for any reason at all, that proper explanation, or translation, is available and ultimately has been provided to me at the time of signing.**

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If you are signing as a personal representative of the patient, please indicate your relationship.

Representative: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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Medicare and an increasing number of commercial insurance carriers **do not** cover *refractions*. \*

The **refraction** is the part of your eye exam where the doctor obtains your **eyeglass prescription**.

**Please choose an option below:**

☐ I choose to pay a discounted rate of \$75 for my refraction today.

☐ I choose to pay \$100 for Contact Lens Fit

☐ I do **not** want to be refracted today.

(Note: your doctor will be unable to give an eyeglass or contact lens Rx without performing a refraction.)

☐ I have routine vision benefits that cover refraction and would like to schedule this appointment for a later date.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\*CMS, the department of the federal government that controls Medicare and Medicaid, has decided that refractions are not a payable part of an eye exam. CMS, directly under control of the US Congress, has determined this is a “noncovered” service. That means you have to pay for that portion of the eye exam.