FIRESIDE EYE CARE, P.C.
WELCOME

Welcome to Fireside Eye Care, P.C. Thank you for choosing us for your eye care needs. We are delighted to have you as a patient. Please take a moment to complete the following information. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.

#7C
☐ Male ☐ Female

First Name | MI | Last Name | Preferred Name

Street Address | City | State | Zip Code

Social Security Number | Date of Birth / / | Home Phone | Work Phone | Mobile Phone

You or your parent's employer | Occupation

Employer's business address | City | State | Zip Code

Spouse or Parent(s) Name | Person Responsible for Account (Must sign at bottom)

Email Address

☐ Please check this box if you do not want email notification for appointment reminders or notification that glasses or contacts have arrived

Preferred method of communication: ☐ Email ☐ Telephone ☐ Postal

Preferred Language:#7C ☐ English ☐ Spanish ☐ Other ____________

Ethinicity:#7C ☐ Hispanic or Latino ☐ Native Hawaiian / Other Pacific Island ☐ NOT Hispanic or Latino

Patient's Status: ☐ Single ☐ Married ☐ Full Time Student ☐ Part Time Student ☐ Employed ☐ Other ____________

How did you hear about us? ☐ Location ☐ Insurance Bklts ☐ Yellow Pgs ☐ Referred by: ____________ ☐ Other ________

PRIMARY ***VISION*** INSURANCE INFORMATION

Name and Address of Primary Insurance Company | City | State | Zip Code

☐ Male ☐ Female | Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth / /

Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

PRIMARY ***MEDICAL*** INSURANCE INFORMATION

Name and Address of Primary Insurance Company | City | State | Zip Code

☐ Male ☐ Female | Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth / /

Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Please read:

I acknowledge that I have had the chance to review the Notice of Privacy Practices and upon request may have a copy. The patient's portion is to be paid at the time services are rendered unless other arrangements are made in advance. The undersigned will be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees in addition to the account balance due. There will be a service charge on all returned checks. Professional services are not refundable, and all product sales are final. Any returns that are approved may be subject to a restocking fee.

I authorize payment from my insurance to be paid directly to Fireside Eye Care, P.C. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. I authorize the use of this form on all insurance submissions and the release of all information to my insurance companies. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I permit copy of this authorization to be used in place of the original.

Signature | Date

FIRESIDE EYE CARE, P.C.
PAYMENT POLICY

OUR PAYMENT POLICY IS DESIGNED TO HOLD DOWN COSTS WITHOUT SACRIFICING THE QUALITY OF THE CARE WE PROVIDE. PLEASE READ THIS POLICY CAREFULLY. IF YOU HAVE ANY CONCERNS OR QUESTIONS, WE WILL BE HAPPY TO DISCUSS THEM WITH YOU.

1. Payment is expected at the time services are received unless specific, individual payment arrangements are made in advance. A deposit of 50% is required prior to ordering materials made to your prescription. The balance is due when you pick them up.

2. For persons desiring credit options, we honor Visa, Mastercard and Discover for your convenience. We also offer interest free financing (if approved) with Care Credit.

3. A cash discount of 5% will be awarded if your total bill is paid by cash, credit card or check at the time services are provided and materials are ordered. The cash discount does not apply to examination fees or safety eyewear and cannot be combined with other discounts or when you have vision insurance.

4. Account balances older than 90 days are considered delinquent and will be subject to legal collection procedures. If your account becomes delinquent, you will be required to pay all reasonable attorney and collection fees incurred in the collection of your account. Accounts which have been referred for collection will not be granted payment options in the future.

5. A monthly service charge of 1.5% will be added to the unpaid balance of your account after 60 days.

6. A service charge of $30 will be levied for any check returned because of insufficient funds or closed account. The check amount plus the service fee must be paid in cash or cashiers check within three days of notification. Failure to comply will result in immediate legal action.

7. You are responsible for knowing your insurance benefits, co-pays, and deductibles. As a courtesy, we will bill your insurance company and/or vision care plan. Some insurers pay you directly. We then require that you pay your account and you will be reimbursed by your insurance carrier. Delayed payment by your insurance is NOT a valid reason for delayed payment to us.

About Your Insurance

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

1. Vision care plans (such as VSP and EyeMed)
2. Medical insurance (such as Blue Cross/Blue Shield and Medicare).
   - Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.
   - Medical insurance must be used if you have any eye health problem or systemic health problem that has ocular complications. The doctor will determine if these conditions apply to you, but some are determined by your case history.
   - If you have both types of insurance plans, it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.
   - We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract.

I have read and agree with these policies.

______________________________ __________________

Signature of Patient Date