Please complete all information so we can do a thorough exam and to be able to file insurance properly.

Date: _____

_____ LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____ NAME YOU PREFER TO BE CALLED

Title: Dr. _____ Master _____ Miss _____ Mr. _____ Mrs. _____ Ms. _____ Other _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Permission To Text: Yes____ No____

Email _____ Sex: M ____ F ____ Drivers License # _____

Date of Birth _____ Age _____ SS# _____

Marital Status: Divorced ____ Separated ____ Single ____ Widowed ____ Married ____

Occupation _____ Full Time ____ Part Time ____ Student ____ Retired ____ Other _____

Employer _____ Work Telephone: ( )_____-_____

Spouse _____ Spouse Employed By _____

Last Eye Exam Date _____ By Whom _____ Do you Wear: Glasses? _____ Contacts? _____

Race: American Indian or Alaska Native____ Asian____ African American ____

Native Hawaiian/Other Pacific Islander ____ Hispanic ____ White ____

Primary Care Physician Name _____

Referred By: (friend, yellow pages, doctor) Name _____

IF UNDER 18 - PERSON RESPONSIBLE FOR PAYMENT

Name _____
LAST FIRST MIDDLE

Street Address _____ City _____ State _____ Zip _____

DOB of Parent / Guardian _____

Telephone: Home ( ) _____ - _____ Work: ( ) _____-_____ Ext. _____

Relationship with Insured: Self / Spouse / Child / Other

Name of Primary Insured _____ Date of Birth _____ SSN _____

SO THAT NO MISUNDERSTANDINGS ARISE, WE WISH TO INFORM YOU OF OUR CREDIT POLICY. Payment for services is expected and due at the time of your visit.

Kindly acknowledge acceptance of this policy by signing and dating the form below:

Signature _____ Date _____

LIFETIME AUTHORIZATION

We request your signature on file, in the event the office files insurance for you or for any office procedure. This clause applies to **all insurance carriers**.

I request that payment of authorized carrier of Medicare benefits be made either to me or on my behalf to Drs. Gossett and Ward for any services furnished me by this/these doctors. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature _____ Date _____

TURN PAGE

Notice of Privacy Practices Patient Acknowledgement

I have had the opportunity to receive this practice's Notice of Privacy Practices. The notice provides the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise those rights, and the practice's legal duties with respect to my protected health information. I understand that the practice may change the terms of its Notice of Privacy Practices and that any changes apply retroactively to information created while the current notice is in effect. I understand I can obtain this practice's current Notice of Privacy Practices upon request.

Initials _____

Medicare Does Not Cover the Refraction or Eyewear

As a convenience to our patients, we are a participating provider for Medicare. We will bill Medicare for your visits. Medicare then reviews all claims, and if approved, reimburses our office 80% of the allowed amount. The remaining 20% is your responsibility, called a co-payment. You may also be responsible for an annual deductible and any non-covered fees. Each January, Medicare starts with a new deductible that must be met before claims are paid. If we are the first to file a claim for you this year, it is likely you will not have met your deductible and will owe for the full allowed amount.

Medicare does not pay for refractive services. This is the vision evaluation part ofthe examination that determines your eyeglass prescription. Medicare will not pay for routine eye exam services. If you have a lens implant as the result of cataract surgery, Medicare will cover lenses, plus frame one time per operation.

Medicare does not cover deluxe frames that are more than the allowance. Standard frames that are completely covered are available. Medicare also does not cover lens treatments such as scratch and antireflective coatings. These charges will be your responsibility.

Signature _____ Date _____

Relationship to patient if guardian _____

Current & Future Contact Lens Wearers

- Additional service fees apply over and above routine eye examination fees.

About Your Vision Care Plan & Your Medical Insurance

There are two types of health insurance that will help pay for your eye health services and products. You may have both types and Drs. Gossett and Ward accept most vision care plans and insurance plans in both categories: (1) vision plans and (2) medical insurance (such as Blue Cross/Blue Shield, Medicare and others).

- Vision plans cover ONLY routine vision wellness exams and may include eyeglasses, sunglasses and contact lenses. Vision plans do NOT provide for MEDICAL EYE HEALTH CARE NEEDS.
- Medical insurance MUST be submitted for any medical eye healthcare diagnoses and treatment care and follow-up.
- If you have both visioncare benefits and medical insurance plans, it may be necessary for us to submit and bill some services to one plan provider and some services to the other plan provider.
- Where some fees for services and products are not paid by your vision plan or medical insurance providers, you will be responsible for them, including deductibles, co-payments and non-provider services as specified by the insurance contract, including refraction. Refraction is a test that is performed to determine your eyeglass prescription. Medicare and many other insurance plans consider a refraction to be routine and is not covered under their medical coverage, so this amount is charged separately and is paid directly by the patient and is due as services are rendered. *Per insurance companies – authorizations DO NOT guarantee payment and will be the patient's responsibility.*
- Please provide both your vision plan provider and medical insurance card(s) and identification, for your benefit, to our team member so we can make a copy. We will need your medical insurance or Medicare card on file in case we should need it in the future for submitting a claim on your behalf with your insurance.

Optical Orders

- The glasses that you order from us are made especially for you with special specifications, so once an Optical product is in production or has already arrived back to the office, there will be no refunds.

I have read and accept these office procedures.

Signature: _____ Date: _____

Smoker (circle) Yes No / Former Smoker Yes No
Blood Disorders (circle) Aids Hepititis HIV none
Are you pregnant or nursing? (circle) Yes No