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

______________________________________________________________________________

*Last Name* *First Name* *Middle initial* *Name you prefer to be called*

**Address:** ____________________________ **City:** ________________ **State:** ____ **Zip:** __________

**Occupation:** ______________________________ **Employer:** ______________________________
**Full Time** ( ) **Part Time** ( ) **Retired** ( ) **Student:** ( )

**Work Phone:** ________________ **Ext:** ____________ **Email:** ________________

**Home Phone:** ______________ **Cell Phone:** ________________ **Permission to Text:** Yes ( ) No ( )

**Title:** Dr ( ) Miss ( ) Mr. ( ) Mrs. ( ) Other:________ **Sex:** M ( ) F ( ) Other ( ) ______________

**Date of Birth** ____/____/____ **Age:** __________ **Social Security#** ______________________

**Race:** American Indian/Alaska Native ( ) Asian ( ) African American ( ) Native Hawaiian/Other Pacific Islander ( )
Hispanic ( ) Caucasian/White ( )

**Marital Status:** Married ( ) Divorced ( ) Single ( ) Separated ( ) Widowed ( ) Other ( )

**Spouse/Partner/Other( Name:)** ____________________________ **Phone#:** ________________

**IF UNDER 18- PERSON RESPONSIBLE FOR PAYMENT:**

**Name:** ______________________________ **Parent** ( ) **Guardian** ( ) **DOB:** __________ **Last 4 of SS#** _____
Full Name

**Address:** ____________________________ **City:** ________________ **State:** ____ **Zip:** __________

**Phone:** ________________ **Relationship to Insured:** **Self** ( ) **Spouse** ( ) **Child** ( ) **Other** ( ) ________________

**Referred by:** ______________________________________________________

**Medical:** Do you wear **Glasses:** Yes ( ) No ( ) **Contacts:** Yes ( ) No ( ) **Date of Last Exam:** ______ **By Whom:** __________

**Height:** __________ **Weight:** __________ **A1C:** ________ if diabetic **Smoker** :Yes ( ) No ( ) **Previous** ( )
**Blood Disorders:** **HIV** ( ) **Aids** ( ) **Hepatitis** ( ) **Pregnant**: Yes ( ) No ( ) **Nursing** ( )

**Consent to Share Confidential Vision/Medical Information:** I hereby authorize Dr. Gossett and Dr. Ward's office to disclose my medical information to the following:

**Full Name:** ______________________________________ **Relationship:** ________________

**Full Name:** ______________________________________ **Relationship:** ________________
I understand that I may cancel this consent at anytime, in writing, but that canceling it will not affect any information that has already been released.

**Signature:** __________________________________ **Date:** ________________________

**SO THAT NO MISUNDERSTANDINGS ARISE, WE WISH TO INFORM YOU OF OUR PAYMENT POLICY:** Payment for services & materials is expected and due at the time of your visit. Balances due after insurance has been filed will be your responsibility and will be between yourself and your insurance to discuss any disputes of covered and non covered services and materials. **We accept Mastercard, Visa, Discover and Care Credit.**

**I have read and understand the Payment Policy:**

**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 Dr's Gossett & Ward for any services furnished to 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:**____________________

**Notice of Privacy Practices Patient Acknowledgment**

**I have had the opportunity to receive this practices 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 _____________

**About Your Vision & Medical Insurance:** **( WE NEED COPIES OF ALL INSURANCE CARDS EACH VISIT )**

**There are two types of insurance that may help with your eye care needs:**

**Medical Insurance:** ***(Medicare, BCBS, Aetna, Humana, etc…)*** as a courtesy we will collect any co-pays and file to your insurance provider. We do not know what your insurance will cover (this is the responsibility of the insured) additional fees may apply such as deductibles, co-pays, non covered, etc…

*Medical Insurance **MUST** be submitted for any medical eye healthcare diagnoses and treatment care and follow-ups.

*If you have both vision care 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.

*Authorizations **DO NOT** guarantee payment or coverage. Insurance Companies such as BCBS, have up to two years to decide to re-coup their payment for any reason they deem necessary, for example, patient not eligible for benefits or non covered services, etc. If insurance decides to recoup payment, balance will then be turned to patient responsibility.

*Please provide both your vision plan provider and medical insurance cards (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. **Co-pays are due at the time of service. We will bill your insurance out of courtesy to you, but it is your responsibility to be sure you are covered for this visit.**

**Medicare does not cover the refraction: Unfortunately, Medicare considers this a routine test and therefore does not approve it making it a non covered service. Since Medicare doesn't cover it, many commercial insurance companies follow suit and also consider it a non-covered service. (Refraction is a test that is performed to determine your eyeglass prescription)**

**Vision Insurance:** Vision insurance covers **ONLY routine vision** wellness exams & may include eyeglasses & contact lenses. Vision plans **DO NOT** provide for Medical eye health care needs.

***Vision insurance:** We accept most vision care plans, if we are a provider for your specific plan we will be able to obtain an authorization of your coverage. (It is the patients/insureds responsibility to contact your insurance to see if we are a provider for you specific plan.)

****Current & Future Contact Lens Wearers***

***Additional service fees apply over and above routine eye examination fees ***

**Optical Orders (Glasses and Contacts)**

*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.

* Contact Lens orders are subject to a 15% restocking fee of the original order price for unopened boxes.

****Referrals and Prior authorizations for Medical visits are the patients responsibility.****

***I have read and accept these office procedures:***

***Signature:***__________________________________________ ***Date:***______________________