ADDITIONAL INFORMATION REQUESTED

PATIENT'S NAME ____ **DATE** _______________________

☐ **Check here if you do not have insurance. You may skip to required signatures on the back of this sheet.**

☐ **Check here if information has not changed since the last visit. You may skip to required signatures on the back of this sheet.**

VISION INSURANCE POLICY INFORMATION – please notify receptionist if you have more than one policy

Insurance companies we contract with: (Circle as many as applicable. Please see the receptionist if your insurance company is not listed.)

CHP+	*Humana*	*PacifiCare*	*TriCare For Life*	*Vision Care Direct*
Colorado Access	*Kaiser*	*Secure Horizons*	*The Resource Exchange*	*Vision Service Plan (VSP)*
EyeMed	*Medicaid*	*Superior Vision*	*UFCW*	
Great West	*Medicare*	*TriCare Prime*	*United Healthcare*	

Primary Insurance ______________________________ ID / Policy #: ____________________ Group #: _________________

IF POLICY HOLDER IS NOT THE PATIENT:

Policy holder ____ Soc. Sec.# ______________________________
Last First Initial (may be necessary for insurance claim filing)

Relationship to Patient: ____ Policy holder's date of birth: __________________

Address ___________________________ City: ________________ State: _____ Zip: __________

Home Phone: (_______)____________________ Cell Phone: (_______)____________________

Employer: _____________________________ Work Phone: (_______)____________________

MEDICAL INSURANCE POLICY INFORMATION – please notify receptionist if you have additional coverage

Insurance Company: ____ Phone: (_______)__________________________

Insurance ID / Policy #: ______________________________________ Group #: ________________________________

IF POLICY HOLDER IS NOT THE PATIENT:

Policy holder ____ Soc. Sec.# ______________________________
Last First Initial (may be necessary for insurance claim filing)

Relationship to Patient: ____ Policy holder's date of birth: __________________

Address ___________________________ City: ________________ State: _____ Zip: __________

Home Phone: (_______)____________________ Cell Phone: (_______)____________________

Employer: _____________________________ Work Phone: (_______)____________________

FOR MEDICARE PATIENTS ONLY: Have you met your out-patient deductible for this year? ☐ Yes ☐ No
Do you have a Medicare supplemental policy? ☐ Yes ☐ No If yes, name of insurance company: ____________________

FINANCIAL RESPONSIBILITY

PAYMENT is expected when services are rendered. Please indicate how you will be paying:

Cash ____ Check ____ Credit Card ____ Insurance (name) ______________________________

Is OPTOM~EYES contracted with your insurance? Y / N (please circle)

Note: As a courtesy to our patients, OPTOM~EYES will file insurance claims for **contracted insurance companies**; however all copayments are due when services are rendered. Any additional charges (such as for deductibles or non-covered charges) will be billed to the policy holder. We do not file out-of-network claims, but will assist in filing such claims upon request. Payment from these companies will be directly to the policy holder and may be at a reduced rate. If you have any questions, please speak to the receptionist before your exam.

For contracted insurances: I, the undersigned, certify that I (or my dependent) have insurance coverage as indicated above and assign directly to my provider all insurance benefits otherwise payable to me for services rendered. I hereby authorize OPTOM~EYES to release all information necessary to secure the payment of benefits, and authorize the use of this signature on all insurance submissions.

FOR ALL: *I understand that I am ultimately responsible for all charges accumulated. In addition, I understand that if this account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, I will be responsible for all costs of collection, including interest (18% per annum, on the unpaid balance), legal fees, and collection agency costs. Returned checks will be assessed a $25 service charge.*

SIGNATURE ______________________________ **PRINTED NAME** ______________________________

Please provide this information if the person signing above is neither the insurance member nor the patient.

Name ______________________________

Relationship to patient?: ______________________________

Address: ______________________________ City: ____________________ State: ______ Zip: __________

Home Phone: (_____)________________ Cell phone: (_____)________________ e-mail: ____________________

Sex: ☐ M ☐ F Age: ________ Date of Birth: ______________ Soc. Sec. #: ____________________

Employer / School: ______________________________ Work Phone: (______)________________

NOTICE OF PRIVACY PRACTICES

NOTICE OF PRIVACY PRACTICES: I acknowledge having had opportunity to review the OPTOM~EYES Notice of Privacy Practices and understand I may keep a copy for my personal files if desired.

SIGNATURE ______________________________