

# Eye & Vision

**Patient Information:** This information is confidential and only used for office purposes such as notices, recalls, confirming appointments and passwords set up to ordering contact lenses online. This information will never be shared.

Mr. Mrs. Miss Dr		
Name	MI	Last Name
Address:		
apt		
City:	State	Zip
Date of Birth:	Age:	Gender:
M/D/Yr.		M F

Email:
Phone:
Cell Phone:
Employer
Occupation

### IMPORTANT INSURANCE INFORMATION:

Your vision plan is intended for "eyeglasses or contact lens" exams. This is limited to your prescription, and a screening for eye disorders. *Vision Plans do not cover* medical eye care (floaters, dry eyes, allergy, lazy eye, Vision loss, red eyes, infections and such) or any prescription for Medication.

If you have a pre-existing condition or any disease that affects vision or Cause blindness (cataracts, glaucoma, dry eye, diabetes, high blood Pressure, cholesterol, etc.) Then your exam will be considered medical Care. These services will be covered by your major medical Insurance. Vision plans do not cover medical eye care. At the time of Service we require both insurance information.

### HIPAA & PRIVACY

\_\_\_\_\_ I have read or been presented with the HIPAA Privacy Policy manual and wish to continue care.

Person responsible for Account:	Relationship: Self Spouse Child
Name:	
Phone:	
<b>Please let us know how you were referred:</b>	
_ Friend Family _ Mail _ Advertisement _ Internet Search	
_ Insurance Other: _____	

### Insurance and Vision Plan information:

<b>MEDICAL INSURANCE:</b>	
Employer	
<b>Insured Name:</b>	
<b>Relationship: Circle one: Self Spouse Child Other</b>	
Ins ID#:	Group#
Ins SS#	DOB
Insurance Phone Number ( )	--

<b>OPTICAL PLAN:</b>	
Employer	
<b>Insured Name:</b>	
<b>Relationship: Circle one: Self Spouse Child Other</b>	
Ins ID#:	Group#
Ins SS#	DOB
Insurance Phone Number ( )	--

- If you do not WRITE DOWN you have Medical Coverage or Vision Plan before service or goods are rendered, we will assume no coverage exists.
- Our Office with NO EXCEPTIONS will not back file claims, post authorize claims or refund professional fees.
- If you discover you have Medical or Vision coverage after professional services or products are rendered, it is your responsibility to file your claim for reimbursement. We will help you file your claim.

*I have read and understand the terms and policies of Eye and Vision and allow Eye and Vision Management to file for Insurance payments or collect payment.  
I certify that the information supplied on this statement is accurate to the best of my knowledge.*

Signed:

Date

*Please do not hesitate to ask if you have any questions*