WALLINGFORD EYE CARE – OFFICE OF DR. SUSAN ROH

WELCOME TO OUR OFFICE

Please complete the following information

Date:______________________________

PATIENT IDENTIFYING INFORMATION				
LAST NAME ☐ MR ☐ MS ☐ DR		FIRST NAME	MIDDLE	
SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX M / F	MARITAL STATUS SINGLE / MARRIED / OTHER	
HOME ADDRESS		CITY	STATE	ZIP CODE
HOME PHONE	WORK OR CELL PHONE	EMAIL ADDRESS		
EMPLOYER (SCHOOL)	OCCUPATION (GRADE)	HOBBIES		

HOW DID YOU HEAR ABOUT OUR OFFICE		
☐ INSURANCE ☐ INTERNET ☐ LOCATION ☐ WORK	REFERRED BY: ☐ FRIEND ☐ DOCTOR	WHOM MAY WE THANK FOR REFERRING YOU?

EMERGENCY CONTACT			
EMERGENCY CONTACT NAME	HOME PHONE	CELL PHONE	RELATION TO PATIENT

IF PATIENT IS UNDER 18 YEARS OF AGE			
NAME OF PARENT / GUARDIAN	HOME PHONE	CELL PHONE	RELATION TO PATIENT

VISION INSURANCE COVERAGE			
NAME OF VISION INSURANCE CO.	POLICY HOLDER (EMPLOYEE)	POLICY HOLDER BIRTH DATE	RELATION TO PATIENT
GROUP NAME	GROUP NUMBER	INSURED ID NUMBER	INSURANCE CO. PHONE #

MEDICAL INSURANCE COVERAGE			
NAME OF MEDICAL INSURANCE CO.	POLICY HOLDER (EMPLOYEE)	POLICY HOLDER BIRTH DATE	RELATION TO PATIENT
GROUP NAME	GROUP NUMBER	INSURED ID NUMBER	INSURANCE CO. PHONE #

I, THE PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE. I ACCEPT RESPONSIBILITY FOR THE VISION AND MEDICAL CHARGES INCURRED BY THE PATIENT AND AGREE TO PAY ALL BILL AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. I AUTHORIZE PHYSICIAN AND CLINIC TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE MY INSURANCE CLAIM TO BE PAID DIRECTLY TO THE CLINIC.

SIGNATURE OF RESPONSIBLE PARTY ____ ***DATE*** ____________

(Over ➔)

WALLINGFORD EYE CARE – OFFICE OF DR. SUSAN ROH

FINANCIAL POLICY

1. **NO INSURANCE COVERAGE**: Payment for all services provided is expected at the time services are rendered. All materials (eyeglasses, contacts, etc.) must be paid for in full before they can be taken from the office. Eyeglass lenses are custom made and cannot be refunded.
2. **INSURANCE COVERAGE**: As a courtesy, we will contact your insurance company for benefit eligibility and coverage. However, cost quotations from the insurance company are not a guarantee of payment. Health insurance is a personal contract between you and your insurance company, thus you are responsible for knowing the limitations of your insurance contract as well as your eligibility for coverage. Should your insurance deny your claim or eligibility for coverage, you are responsible for all fees accrued in your behalf.
3. **ACCOUNTS WITH OUTSTANDING BALANCE:** Bills must be paid within 30 days from receipt of statement, unless other arrangements are made; if full payment has not been received within 30 days, the account will be past due and a 12% finance charge will be added to the balance. Returned checks are subject to a $50.00 processing fee.
4. **INITIATION OF COLLECTION PROCEEDINGS:** All accounts that are 90 days past due will be referred for collection proceedings. In the event collection proceedings are initiated, you will be responsible for any interest accrued on the balance and all billing fees, i.e., collection cost, attorney fees, court costs, etc.

I have read, understand and agree to follow the Financial Policy of Wallingford Eye Care. I understand that I am ultimately responsible for payment of the account. I authorize payment of insurance benefits to this office. I also authorize release of any medical records necessary to process any insurance claims.

SIGNATURE OF RESPONSIBLE PARTY ______________________________ ***DATE*** __________

HIPAA PRIVACY POLICY

Your medical records are confidential and we make every effort to preserve that confidentiality. I understand that by signing this consent form, I am allowing my medical information to be released to requesting physicians and insurance companies for the purpose of health care operations (including but not limited to provider reviews, claims payment, and quality assessment). I understand that I may revoke this consent by written request at any time. If revoked it is understood by all parties that all information released prior to being notified of such revocation was made by consent.

The uses and disclosures of protected health information for marketing purposes, disclosures that constitute a sale of protected health information, and other uses and disclosures not described in this policy require my authorization.

I have the right to restrict certain disclosures of protected health information to a health plan if I pay out of pocket in full for health care item or service.

In the event there is a breach of my unsecured protected health information, I have the right to receive notification of such breach.

I understand that I have the right to restrict disclosure of specific information in my medical records if I request such restriction in writing. I understand that my request for restriction may be denied if the information restricted is required for health care operations.

I have read the above and foregoing consent for release of information and acknowledge and understand the terms and conditions of the consent.

SIGNATURE OF RESPONSIBLE PARTY ______________________________ ***DATE*** __________

OPTIONAL:

I give permission to the following individual(s) to have access to my confidential medical information:

Name: ________________________ Relationship to Patient: ____________ Phone #: __________

Name: ________________________ Relationship to Patient: ____________ Phone #: __________