Vision Care Consultants

DATE_____

LAST NAME FIRST M.I. TITLE SUFFIX NICKNAME

MAILING ADDRESS CITY STATE ZIPCODE

DATE OF BIRTH AGE HOME PHONE # CELL PHONE #

SOCIAL SECURITY NUMBER EMAIL ADDRESS

☐ MALE ☐ FEMALE

MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED
EMPLOYER STATUS ☐ EMPLOYED ☐ NOT EMPLOYED ☐ STUDENT

EMPLOYER OCCUPATION EMPLOYER PHONE #

PREFERRED LANGUAGE ☐ ENGLISH ☐ SPANISH
RACE ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ ASIAN ☐ AMERICAN INDIAN OR ALASKA NATIVE
☐ NATIVE HAWAIIAN OR PACIFIC ISLANDER ☐ OTHER
ETHNICITY ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO

IF YOU ARE A NEW PATIENT, WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON RESPONSIBLE FOR THIS ACCOUNT (FILL THIS IN IF PATIENT IS A MINOR)

LAST NAME FIRST M.I.

RELATIONSHIP TO PATIENT SOCIAL SECURITY NUMBER DATE OF BIRTH

MAILING ADDRESS CITY STATE ZIPCODE

PHONE # NAME OF EMPLOYER

INSURANCE INFORMATION (PLEASE GIVE THE RECEPTIONIST COPIES OF ALL INSURANCE CARDS)

POLICY HOLDER NAME RELATIONSHIP TO PATIENT

POLICY HOLDER DATE OF BIRTH **POLICY HOLDER** SOCIAL SECURITY NUMBER

MEDICAL / HEALTH INSURANCE COMPANY **VISION INSURANCE COMPANY**

FINANCIAL RESPONSIBILITY

PAYMENT IS REQUIRED AT THE TIME OF SERVICES ARE RENDERED. THIS INCLUDES APPLICABLE CO-INSURANCE AND CO-PAYMENTS FOR PARTICIPATING INSURANCE COMPANIES. VISION CARE CONSULTANTS ACCEPTS CASH, DEBIT, PERSONAL CHECKS, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, AND CARECREDIT. THERE IS A SERVICE CHARGE OF $25.00 FOR ALL RETURNED CHECKS.

FINANCE CHARGES WILL APPLY TO ANY OUTSTANDING BALANCES 60 DAYS AND OVER. PATIENTS WITH AN OUTSTANDING BALANCE THAT IS 30 DAYS OVERDUE MUST MAKE ARRANGEMENTS FOR PAYMENT, PRIOR TO SCHEDULING APPOINTMENTS.

NO REFUND WILL BE MADE ON CLINICAL PROCEDURES OR SERVICES, INCLUDING, BUT NOT LIMITED TO, COMPREHENSIVE EYE EXAMINATION, CONTACT LENS FITTING, AND MEDICAL OFFICE VISITS.

CANCELLATION / NO-SHOW POLICY

WE UNDERSTAND THAT THERE ARE TIMES WHEN YOU MUST MISS AN APPOINTMENT DUE TO EMERGENCIES OR OBLIGATIONS FOR WORK OR FAMILY. HOWEVER, WHEN YOU DO NOT CALL TO CANCEL AN APPOINTMENT, YOU MAY BE PREVENTING ANOTHER PERSON FROM GETTING MUCH NEEDED TREATMENT. CONVERSELY, THE SITUATION MAY ARISE WHERE ANOTHER PATIENT FAILS TO CANCEL AND WE ARE UNABLE TO SCHEDULE YOU FOR A VISIT, DUE TO A SEEMINGLY “FULL” APPOINTMENT SCHEDULE.

IF YOU NEED TO CANCEL OR RESCHEDULE YOUR APPOINTMENT, WE MUST HAVE **AT LEAST A 24-HOUR NOTICE.** WE **DO NOT** ACCEPT CANCELLATIONS VIA TEXT OR EMAIL. AN APPOINTMENT IS CONSIDERED A “NO-SHOW” IF YOU DON’T SHOW UP FOR AN APPOINTMENT WITHOUT CANCELLING AT LEAST 24 HOURS PRIOR, **OR** IF YOU SHOW UP **5 OR MORE MINUTES LATE. LATE CANCELLATIONS AND “NO-SHOW” APPOINTMENTS MUST MAKE A FIFTY DOLLAR ($50.00) DEPOSIT BEFORE SCHEDULING ANY FUTURE APPOINTMENTS.**

_____

SIGNATURE OF PATIENT, PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE

_____

PRINT NAME OF PATIENT, PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE

_____

DATE

INSURANCE AUTHORIZATION

WE BILL PARTICIPATING INSURANCE COMPANIES AS A COURTESY TO YOU. IF YOU ARE SEEING THE PHYSICIAN FOR A ROUTINE VISION VISIT, YOU MUST NOTIFY US UPON CHECK-IN. WE WILL NOT RE-FILE INSURANCE CLAIMS IN ORDER TO RECEIVE ROUTINE VISION BENEFITS. THIS WOULD BE CONSIDERED FRAUDULENT BILLING SUBJECT TO FINES AND PENALTIES. VISION CARE CONSULTANTS IS NOT RESPONSIBLE FOR COLLECTING INSURANCE INFORMATION AFTER THE DATE OF SERVICE. THE AMOUNT WILL BE BILLED TO THE PATIENT OR RESPONSIBLE PARTY IF INFORMATION IS INCORRECT OR IS NOT GIVEN.

I UNDERSTAND THAT DR. MICHAEL KILLOUGH IS AN OPTOMETRIC PHYSICIAN, AND THAT IN ADDITION TO VISION AND CONTACT LENS SERVICES THAT HE PROVIDES, HE ALSO IS LICENSED TO PROVIDE MEDICALLY NECESSARY OCULAR PROCEDURES AND SERVICES. THESE PROCEDURES AND SERVICES ARE ACCEPTED BY MOST MEDICAL INSURANCE COMPANIES. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS AND THE RELEASE AND TRANSFER OF ANY INFORMATION REQUIRED IN OBTAINING PAYMENT FOR SERVICES OR DETERMINING INSURANCE BENEFITS. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE EITHER TO VISION CARE CONSULTANTS OR DR. MICHAEL KILLOUGH FOR ANY SERVICES FURNISHED TO ME. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE CARRIER. I HAVE BEEN NOTIFIED THAT VISION CARE CONSULTANTS WILL FILE MY INSURANCE AND IF THE INSURANCE DENIES OR APPLIES THE AMOUNT TO THE DEDUCTIBLE **I WILL BE PERSONALLY AND FULLY RESPONSIBLE FOR THE BALANCE.**

_____

SIGNATURE OF PATIENT, PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE

_____

PRINT NAME OF PATIENT, PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE

_____

DATE

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

PATIENT'S NAME_____D.O.B._____ SSN_____

BELOW IS A LIST OF PERSONS THAT YOU GIVE PERMISSION FOR OUR CLINIC TO DISCUSS AND USE THE PATIENT'S PROTECTED HEALTH INFORMATION, INCLUDING CONDITION AND TREATMENT PLAN, TEST RESULTS, PRESCRIPTIONS:

NAME	**RELATIONSHIP TO YOU**	**TELEPHONE #**
_____	_____	_____
_____	_____	_____
_____	_____	_____

I UNDERSTAND THAT IT IS **MY** RESPONSIBILITY TO UPDATE THIS LIST IN ORDER TO KEEP ACCURATE THOSE AUTHORIZED PERSONS TO DISCUSS AND USE THIS PATIENT'S HEALTHCARE INFORMATION.

_____

SIGNATURE OF PATIENT, PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE **DATE**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I RECEIVED A COPY OF VISION CARE CONSULTANTS' NOTICE OF PRIVACY PRACTICES.

_____ _____

PRINT NAME OF PATIENT **SIGNATURE** OF PATIENT (**IF PATIENT IS 18 YEARS OR OLDER**)

_____

PRINT NAME OF PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE **(IF APPLICABLE)**

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SIGNATURE OF PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE **RELATIONSHIP TO PATIENT**

DATE_____