

FAMILY EYE CARE CENTER OF JACKSONVILLE

PATIENT INFORMATION AND AUTHORIZATION

PAGE 1

DATE _____

Patient Name _____ Male Female
Social Security No. _____
Birthdate _____
Home telephone _____ Work Telephone _____
Cell Phone _____
Address _____
City _____ State _____ Zip _____
Employer _____
Business Address _____
City _____ State _____ Zip _____
Responsible Party for Account _____
Person to Contact in case of emergency _____ Telephone _____

The following must be read and signed. They are not negotiable and may not be edited or changed. If you choose not to sign or wish to edit them, services cannot be provided to you at this office. Thank you.

1. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also authorize payment of insurance benefits directly to the doctor. I agree to release information about my health to other doctors for the benefit of my obtaining important information regarding diagnosis and treatment of my eye problems.
2. I understand that most insurances including Medicare do not cover a "refraction" which is an important test used to determine if I need glasses to see better. I understand that I will need to pay **\$98.00** before this service is provided unless I indicate that I do not want a refraction or my insurance clearly covers it as indicated by the front desk staff. **I also understand no form of contact lens work is provided by this office.** Premature infants will not be provided services in this office.
3. **If I am in this office for a double vision evaluation** I understand that part of the visit, the "prism refraction" is not covered. The cost of this important test is **\$395.00 payable before the service is rendered.** **Follow up appointments for Prism Refraction work are \$165.00 per visit.** Information about this important non-covered test is available at the front desk by request. **A \$250 deposit is required for all Prism appointments and is non-refundable.**

Date: _____

Signature of patient or legal guardian

____ - ____ - _____ Responsible Party Social Security Number

4. I understand that if I have brought children with me that if they play with and break any medical equipment in the medical examination rooms that I will be responsible to pay in full. A receipt will be provided to me regarding the cost of the instrument which is broken. * **No minors may be left unattended in any part of this office.** * A Parent/Legal Guardian must attend all appointments for minors (Ages 0-18).

5. I understand a \$75.00 fee will be assessed for any office appointment cancelled without 24 hours notice and a \$250.00 fee will be assessed for any patient surgical appointment cancelled without exception. If a Monday appointment needs to be cancelled, it is necessary to cancel by the previous Friday, no later than 12:00 p.m., or a \$75 administrative fee applies. If you cancel a surgery set up appointment without 24 hours notice a \$100 fee will be assessed. If surgery is cancelled your deposit will be retained. No credit will be issued. *Patients who fail to appear for prism refraction appointments will be assessed a fee of \$250.00. If a prism refraction appointment is cancelled a \$250.00 fee will apply. If a visual field appointment is cancelled within 24 hours, or the patient fails to appear to the scheduled appointment, a \$75 fee will apply.* If an account is turned over to a collection agency additional collection fees will be applied. Our practice also reserves the right to discharge patients with 30 days notice who fail to keep appointments with this office. Late fees will apply after the ten day grace period for any past due balance.

6. I understand that this office will provide me with a copy of my medical records by my written signature at the time of the request, with a charge of \$1.00 per page, up to 25 pages, then .25 (25 cents) for each additional photocopy over 25 pages, plus \$10.00 for faxing or mailing.

7. I understand that if my health insurance has a **deductible** I am responsible to pay contracted rates at the time of the office visit. I also understand that if my health insurance has a **co-pay** responsibility it will be collected before services rendered. This will also apply for follow up visits. If this office determines that my deductible has not been met after receipt of an explanation of benefits from my insurance company, it is my responsibility to pay for services rendered within 10 days of receiving a bill. **I understand that the responsibility of determining the amount remaining on my insurance deductible, primary or secondary insurance, is MINE ALONE.**

8. I understand that I am responsible to pay my medical bill and that if my insurance does not pay this office within 60 days from date of service that I will pay for the services rendered. All co-payments must be paid before services are provided. If I fail to pay for any reason I understand that I will be held responsible for payment, including all costs and penalties associated with our collections company, and will be reported to all three credit bureaus for failure to pay.

Signature or patient or legal guardian

Date

Family Doctor (PCP) _____
or Pediatrician (name)

(telephone #)