# Welcome to Envision EyeCare

ENVISION EYECARE
Missoula • Montana

## PATIENT INFORMATION

First Name_____MI___Last Name_____Called Name_____

Address_____ Home Phone_____

City_____State____Zip_____ Work Phone_____

Date Of Birth_____/_____/_____ Gender_____ Cell Phone_____

Social Security #_____-_____-_____ Email_____

Student: FT/PT Employed: FT/PT Are you OK with Text/Email Communication? YES NO

Employer_____ Occupation_____

Marital Status: Single / Married / Other Spouses Name:_____

How did you hear about us?_____ If referred, whom may we thank?_____

### RESPONSIBLE PARTY (*IF PATIENT IS UNDER 18*)

First Name_____MI___Last Name_____Relationship_____

Date of Birth_____/_____/_____ SSN_____-_____-_____ Phone_____

Address (*if different than above*)_____ City, State, Zip_____

## INSURANCE INFORMATION

| VISION INSURANCE | MEDICAL INSURANCE |
|---|---|
| Company_____ | Company_____ |
| Subscriber ID#_____ | Subscriber ID# _____ |
| Group ID#_____ | Group ID#_____ |
| Policy Holder □Self □Spouse □Other | Policy Holder □Self □Spouse □Other |

### PRIMARY INSURED'S INFORMATION (*IF NOT SELF*)

Name: _____ Date of Birth_____/_____/_____SSN_____/_____/_____

Address (*if different than above*)_____ City, State, Zip_____

### ABOUT YOUR INSURANCE

There are two types of health insurance that will help pay for your eye care services and optical products. You may have both types and Envision EyeCare accepts most insurance plans in both categories: 1) Vision Plans (such as VSP, Eyemed and Spectera) and 2) Medical Insurance (such as Blue Cross/Blue Shield, Medicare and others).

●Vision Plans only cover **routine vision exams**, and in some cases, eyeglasses and/or contact lenses. Vision plans do not cover medical eye care (the diagnosis, management or treatment of eye health problems).

●Medical Insurance **must be used** if you have any eye health problem that has ocular complications. Your doctor will determine if these conditions apply to you.

●If you have both types of insurance plans, it may be necessary for us to bill some services to one plan and some services to the other. We follow a procedure called coordination of benefits to do this properly and to minimize your out-of-pocket expense.

●If some fees are not paid by your insurance, we will bill you for them, such as deductibles, co-pays or non-covered services as allowed by the insurance contract.

OVER→

1. FINANCIAL POLICY: I agree to pay Envision EyeCare and its assigns, for any and all serves or expenses incurred as the responsible person on this account. I understand that the bills are payable in full upon the rendering of treatment. However, Envision EyeCare will bill any applicable insurance as a courtesy. I assign Envision EyeCare all benefits due me for services rendered and expense incurred under and applicable policy of insurance. I understand that I am financially responsible to Envision EyeCare for all charges and services not covered by this assignment and promise to pay any remaining balance.
2. COLLECTION POLICY: I understand that in the event any unpaid balance is placed for collections with any third party collection agency, a fee of 50% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, late fees, and any other fees so stated elsewhere. The authorized fee of 50% and the additional costs listed above represent the actual costs incurred by Envision EyeCare to collect amounts owed under this agreement and a corresponding decrease in expected revenue resulting from this signer's failure to pay as specified in this agreement.
3. EYEGLASS PURCHASE POLICY: All sales are final. Many frames are under a warranty and may be replaced for manufacture's defects within the warranty period. Once an order is sent to the lab, it may not be cancelled. Prescription changes will be performed at no charge for 60 days following the original date of service.
4. CONTACT LENS POLICY: It is required to have a contact lens fitting each year. There is a fitting fee which will cover follow-ups and the cost of the trial contact lenses. We will gladly exchange and or issue a refund for any unopened boxes of contact lenses that were purchased at Envision EyeCare.
    - A copy of your contact lens prescription will be emailed to you in compliance with the Fairness to Contact Lens Consumer Act

**MEDICAL DICLAIMERS**

- I acknowledge that refusing a retinal examination (dilation or Optomap) that the doctor will not be able to do a thorough health examination of my eyes and also may not be able to diagnose possible vision and/or life-threatening disorders without this examination.
- I understand that choosing to have my eyes dilated carries a minimal risk of acute angle closure.

**NOTICE OF PRIVACY PRACTICES**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996(HIPPA). I have been informed and given the right to review and secure a copy of your notice of Privacy Practices which contains a complete description of the uses and disclosures of my protected health information and my rights under HIPPA.

By signing below I acknowledge that I have completely read and understand the above policies and disclaimers.

_____
PRINT PATIENT NAME

_____ Date:_____
Patient or Legal Guardian SIGNATURE

I would like to opt in to having my statement emailed to me YES NO (circle one)