CHIPPEWA VALLEY EYE CLINIC

PATIENT INFORMATION

Name: ____

Date of Birth: _______________________ Sex: M / F

Address: ____

Home Phone: _________________________________

City/State/Zip: _____________________________________

Cell Phone: __________________________________

Social Security #: _______________________________

Work Phone: _________________________________

Email: ____

Marital Status: Single / Married / Divorced / Widowed

Employer: _____________________________________

RESPONSIBLE PARTY/GUARANTOR INFORMATION

Name: ____

Date of Birth: _______________________

Address: ____

Home Phone: __________________________________

City/State/Zip: _____________________________________

Cell Phone: ___________________________________

Social Security #: _______________________________

Work Phone: __________________________________

Relationship to Patient: ___________________________

Email: ____

PRIMARY INSURANCE INFORMATION

Name of Insured: __________________________________

Relationship to Insured: Self / Spouse / Child / Other

Insured SS#: ____/_____/_______ Birth Date: ___________

Employer: ____

Insurance Name: _________________________________

ID#: ___________________________ Grp#: ___________

SECONDARY INSURANCE INFORMATION

Name of Insured: ______________________________

Relationship to Insured: Self / Spouse / Child / Other

Insured SS#:_____/_____/_______ Birth Date: _______

Employer: ______________________________________

Insurance Name: ________________________________

ID#: ___________________________ Grp#: __________

WORKER'S COMPENSATION INFORMATION

Is this a worker's Comp: YES or NO If Yes, Date of accident: ___________________ Employer Notified: YES or NO

Employer Name / Phone#: ___________________________ /______________________ WC Claim #: ________________

*Please note that if you have not reported this injury to your employer, you may be responsible for payment of injury related services. Injury should be reported ASAP and an Injury Report completed.

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

RELEASE OF INFORMATION: I understand and authorize Chippewa Valley Eye Clinic to disclose the PHI necessary for reimbursement of services rendered under Treatment, Payment, and Operations to my insurance(s), Worker's Compensation and Health Care Financing Administration any information about me needed to determine these benefits or the benefits payable of my bill.

INSURANCE AGREEMENT Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to Chippewa Valley Eye Clinic for any services furnished to me by their physicians. If co-payments and/or deductibles are designated by my insurance company or my health plan I agree to pay them to Chippewa Valley Eye Clinic. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Chippewa Valley Eye Clinic, if I belong to a plan that is not on their list of contracts.

PLEASE TURN OVER TO COMPLETE…

NON-COVERED SERVICES: I understand that Chippewa Valley Eye Clinic's contracts with health care service plans (i.e. HMO's, PPO's) relate only to items and services, which are "covered" by the health care service plans.
Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services such as Refractions, Corneal Topography; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Chippewa Valley Eye Clinic, to obtain necessary health care service plan authorizations.

FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Chippewa Valley Eye Clinic, I will pay my co-pay at the time service is rendered and any account balance including deductible and co-insurance at the time of invoicing or will make financial arrangements satisfactory to Chippewa Valley Eye Clinic, for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice.

REFRACTIONS: In most cases you will be responsible for the "**Refractions**". This service is the determination of the need for glasses or change in your current glasses prescription. This is considered a "**Non-Covered**" service by Medicare, or routine care. Most secondary carriers do not cover this service since Medicare does not allow it. Therefore, payment is due from you upon completion of your eye examination for the "**Refraction**". We will still submit this charge to your primary and secondary insurance.

CONTACT LENS EXAMS: There is an additional charge for contact lens exams. This fee is charged once a year and is applicable even if you do not order contacts from Chippewa Valley Eye Clinic.

COMMUNICATION PRIVACY NOTICE: By supplying my home phone number, cell phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing the above detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

HIPAA NOTICE: Chippewa Valley Eye Clinic's Notice of Privacy Practice is available at www.cveclinic.com/Patient-forms . I acknowledge that a printed version is also available at my request.

I HAVE READ, UNDERSTAND AND AGREE WITH THE RELEASE OF INFORMATION, INSURANCE AGREEMENT, NON-COVERED SERVICES, FINANICAL AGREEMENT AND REFRACTIONS LISTED ON THE FRONT AND BACK OF THIS DOCUMENT.

____ _______________________

PATIENT BENEFICIARY/RESPONSIBLE PARTY/GUARDIAN SIGNATURE **DATE**

I grant the following person(s) permission to speak with Chippewa Valley Eye Clinic regarding my medical records, treatment, and billing.

Name: _______________________________ **Relationship:** ____________________

Name: _______________________________ **Relationship:** ____________________

***** PLEASE BRING THESE COMPLETED FORMS TO YOUR APPOINTMENT *****