CHIPPEWA VALLEY EYE CLINIC **** PLEASE BRING COMPLETED FORMS TO YOUR APPOINTMENT ****

PATIENT INFORMATION

Name _____ Marital Status: Single / Married / Divorced / Widowed

Address _____Apt/Lot#_____ Date of Birth _____ Sex: M / F / Decline

City/State/Zip: _____ Phone (H)_____(W) _____

Social Security # _____ Cell Phone _____

Email _____ Employer _____

Race _____ Occupation _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other _____

Language: ☐ English ☐ Spanish ☐ Hmong ☐ Other (specify) _____

GUARDIAN / GUARANTOR INFORMATION – Must be filled in for patients under 18

Name: _____ Date of Birth: _____ Email: _____

Address: _____Apt/Lot#_____ Phone: (H)_____(W) _____

City/State/Zip: _____ Cell Phone: _____

Social Security #: _____ Relationship to Patient: _____

PRIMARY INSURANCE Name: _____

ID# _____ Grp# _____

Subscriber Name:_____

Relationship to Insured: Self / Spouse / Child / Other

Subscriber SS#: _____ Birth Date: _____

Employer: _____

SECONDARY INSURANCE Name: _____

ID# _____ Grp# _____

Subscriber Name: _____

Relationship to Insured: Self / Spouse / Child / Other

Subscriber SS#: _____ Birth Date: _____

Employer: _____

WORKER'S COMPENSATION INFORMATION - Is this a Work Comp visit? YES / NO Date of accident: _____

Employer Notified? YES / NO Employer:_____ Phone#_____

WC Claim #: _____ *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.

Emergency Contact: _____ Relationship:_____ Phone:_____

PHI Release Authorization: I grant Chippewa Valley Eye Clinic permission to share my medical records, treatment, & billing info to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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 has been offered to me and is also available at my request.

I CERTIFY THAT THE INFORMATION I HAVE SUPPLIED REGARDING MYSELF OR MY DEPENDENT IS ACCURATE AND COMPLETE.

_____ _____

Patient / Guardian Signature **Date**

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SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

*In return for the services I receive and/or have received from Chippewa Valley Eye Clinic ("**Provider**"), I agree to:*

1. **Assignment of Benefits** 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 to be individually obligated to pay the full charges of all services rendered by Chippewa Valley Eye Clinic, if I belong to a plan that is not on their list of contracts. These assigned, transferred rights include, but are not limited to:

   a) The right to receive payment for any medical bills incurred as a result of services provided by Provider;
   b) The right to obtain information about My Coverage, including but not limited to information about plan features / funding;
   c) The right to appeal any adverse benefit determination or other denial;
   d) The right to bring fiduciary duty claims or seek declaratory or injunctive relief or penalties on my behalf;
   e) The right to submit any dispute in my name to binding arbitration.

   I permit a copy of this Agreement to be used in place of the original for the purpose of obtaining payment under My Coverage. To the extent my rights are alleged to be non-assignable, in addition to my appointment of an authorized representative below, I retain the right to payment but direct & authorize My Coverage to send any payment, payable to me, direct to Provider.

2. **Limited Power of Attorney & Appointment of Authorized Representative** In the event My Coverage does not accept my assignment, or My Coverage prohibits my assignment of certain or all rights or benefits, or my assignment is otherwise challenged or deemed invalid, I execute this limited power of attorney and irrevocably designate, authorize, and appoint Provider and Provider's attorney ("**My Representative**") as my agent, personal/authorized representative, and attorney for the limited purpose of collecting payment for Provider's services directly against My Coverage, in my name, including but not limited to administrative and other appeals and arbitration/litigation. I specifically authorize My Representative to file directly against My Coverage in my name or in Provider's name as a medical provider rendering services to me.
   I further grant a limited power of attorney to Provider as my medical provider to receive and collect directly from My Coverage any and all money due Provider for services rendered to me, and instruct My Coverage to pay Provider directly any monies due Provider for medical services that Provider provided to me. I also agree that any fines, interest, attorney fees, or other awarded damages that may be levied against My Coverage will be paid to Provider when acting as My Representative.
   This limited power of attorney shall automatically terminate, without formal action, as soon as Provider receives payment in full and the remedies available under applicable regulatory guidelines for the medical care services that Provider provided to me.

3. **Cooperation** I agree to cooperate with Provider to pursue all available remedies, benefits, payment. I agree to fulfill any reasonable request from Provider ie; signing correspondence or obtaining information about My Coverage from my employer or insurer. I agree that no guarantees have been made to me as to the results of examination/treatment provided to me by Provider.

4. **Insurance, Health Benefits Coverage, and/or Medical Assistance** **It is my responsibility to provide Provider with current and accurate My Coverage and/or medical assistance program(s) information at the time of service**. I certify that the information given by me under My Coverage and/or medical assistance program(s) is correct. I authorize Provider to release any information about me which is properly needed for processing and paying My Coverage and/or medical assistance program(s) claims.

5. **Responsibility for Payment** I understand that am responsible for all amounts not otherwise paid, in whole or in part, by My Coverage, including but not limited to **co-payments, deductibles, co-insurance,** & **non-covered services** under My Coverage. I agree to pay for all charges that are due for my care/treatment by Provider in accordance with Provider's regular rates/terms. I agree to pay any co-payments at the time of service. I also understand that I am responsible for paying Provider in full for services My Coverage will not cover due to non-payment of any premiums required by My Coverage. I understand that although Provider may file claims with My Coverage as a courtesy to me, I am ultimately responsible to pay for the services received.

6. **Communication privacy notice** By supplying my home phone number, cell phone number, email address, 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, 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.

I certify that I have read and understand this Agreement and had the opportunity to ask questions. For a minor patient, I attest that he/she is a beneficiary under My Coverage; I sign as a parent/guardian as the person financially responsible for payment for medical bills. I agree that this constitutes the sole and entire agreement between me and Provider regarding the subject matter of this Agreement.

Patient / Guardian Signature **Date**