

PACIFIC EYECARE OF BREMERTON

PATIENT NAME: _____ SSN: _____ Male/Female
Birthdate: _____ Home Phone: _____ Daytime Phone: _____
Address with City, State & Zip: _____
How were you referred to us: _____
Employer: _____
Marital Status: _____ Spouse Name: _____
Emergency Contact(s) with Phone numbers--other than those on the Privacy Policy Statement:

GUARANTOR INFORMATION (IF DIFFERENT FROM PATIENT or PATIENT IS A MINOR):
Guarantor: _____ Relation to Patient: _____
Birthdate: _____ Home Phone: _____ Daytime Phone: _____
Address with City, State & Zip: _____
Employer: _____ SSN: _____
Person who brought in child: _____ Relation to Pt: _____

Subscriber Information (if different from patient): Please be aware that as of 10-16-03 HIPAA regulations state that claims lacking any of the subscriber information will not be processed (whether the insurance is primary, or we are billing a secondary or tertiary insurance.) The information needed is listed below. If you do not provide us with this information, we will not be able to bill your claims.

INSURANCES: Please present insurance cards to copy for billing information.

**** MEDICAL (PLEASE LIST PRIMARY AND SECONDARY):**

Primary Ins: _____ Secondary Ins: _____
Subscriber: _____ Subscriber: _____
Member Number: _____ Member Number: _____
Subscriber DOB: _____ Subscriber DOB: _____
Subscriber SSN: _____ Subscriber SSN: _____

If address is different than above, please give us the subscriber's address:

**** VISION COVERAGE (PLEASE LIST PRIMARY AND SECONDARY):**

Primary Vision: _____ Secondary Vision: _____
Subscriber: _____ Subscriber: _____
Member Number: _____ Member Number: _____
Subscriber DOB: _____ Subscriber DOB: _____
Subscriber SSN: _____ Subscriber SSN: _____

*******IMPORTANT*******

PLEASE READ THE FINANCIAL STATEMENT ON THE BACK OF THIS PAGE. YOUR SIGNATURE ALSO ACKNOWLEDGES THAT YOU HAVE READ, UNDERSTAND AND AGREE TO THE PROVISIONS OF OUR FINANCIAL POLICY. A COPY IS PROVIDED TO YOU BY REQUEST, AND THIS ORIGINAL WILL BE KEPT ON FILE FOR YOU.

PATIENT SIGNATURE: _____ **DATE:** _____

FINANCIAL POLICY

- **PRIVATE PAY SERVICES NEED TO BE PAID FOR AT THE TIME OF SERVICE.**
- Please present your insurance card(s) so we may make a copy of them for your file. Insurance not given at the time of service may not be billed at a later time. *It is the patient's responsibility to know their coverage and eligibility.*
- **PLEASE NOTE THAT THE PATIENT IS ULTIMATELY RESPONSIBLE FOR ALL BALANCES, EVEN THOSE BILLED TO INSURANCE.** We bill insurance as a courtesy for our patients. We do our best to collect from insurance that we are providers for, but there are instances when the person who pays the insurance premium can get better and faster results from the insurance than the provider.
- **IT IS THE PATIENT RESPONSIBILITY TO GET REFERRALS** from the **Primary Care Physician (PCP)** or preauthorization from your insurance **PRIOR** to services. The PCP's want to hear directly from the patient before outside appointments are made. The majority of managed care plans do not backdate referrals. Patients will be billed privately for any service where we do not have a referral in office at the time of service.
- **COPAYS ARE ALWAYS DUE AT THE TIME OF SERVICE.** Please do not wait for us to ask you for your copay. Offer it willingly as you know it is due.
- It is the patient's responsibility to let the office know if you want a service billed as **ROUTINE OR MEDICAL** AT THE TIME OF SERVICE. There might be times when your complaints may warrant a medical visit when you feel you are actually there for a routine complaint, or visa-versa. Please let your doctor know how you want it billed, otherwise he or she will bill it as the complaint warrants.
- If your insurance requires a specific form unique to them, please provide that at the time of service with the patient and employee information filled out and signed.
- In the case of a minor child being brought in by a custodial parent or other person who is not the guarantor of the child's insurance, please be aware that the parent or person(s) who brings in the child for the treatment is ultimately responsible for the child's account balance. A minor child will not be treated unless there is an adult with them.
- **Contact lens fittings and adjustments need to be paid for at the time of service.** These services are non-refundable. **CONTACT LENSES NEED TO BE PAID FOR IN FULL AT TIME OF PICKUP.** There is a 90 day refund policy on *non-disposable*-types of lenses. If you have hardware coverage for contacts, tell us at the time of ordering. It is the patient's responsibility to know their coverage and eligibility.
- Our office accepts cash, personal checks, debit cards, VISA, Mastercard and Discover credit cards.

A COPY OF THIS FINANCIAL POLICY IS AVAILABLE TO YOU UPON REQUEST.