

NEW PATIENT INFORMATION

Patient Last Name _____ First _____

Date of Birth _____ Age _____ (circle) Male Female

SS# _____

(circle) married single other Work: Full time Part-time Student Retired Other

Occupation _____

Home Phone _____ Work Phone _____

Address _____

City _____ State _____ Zip _____

Email _____

Why did you choose our office, or who referred you?

Person responsible for account if not self _____
relationship _____

Vision insurance _____

Policy holder _____ DOB _____

Medical insurance _____

Policy holder _____ DOB _____

Secondary insurance _____

Policy holder _____ DOB _____

When was your last eye exam? _____ With Dr. _____

Did your previous eye doctor find anything wrong with your eyes other than needing eyeglasses?

Payment Terms (all patients): Payment for exam, contact lens fitting/evaluation, and co-payment is required the day of your exam. We accept cash, checks, MasterCard, Visa, Discover, and American Express. A deposit of 50% is required on all eyeglass or contact lens orders. The balance is due on the day of picking up eyeglasses or contact lenses. Overdue accounts will be charged interest at 1.5% monthly after 30 days. Accounts 90 days past due will be submitted to a collections agency and patients will be billed for collections costs of 35% of the balance added to cover the cost of collection fees and a \$25 processing fee added to my balance. All payments and communication will cease with New Hartford Eyecare and be referred to the Collection Agency. There is a \$30 fee for returned checks.

Insurance Billing: As a courtesy, our office may call your insurance company to obtain benefits information, but this is not a guarantee that your insurance will pay. It is your responsibility to know what your insurance is, your specific plan and benefits, and whether you are eligible to use your benefits at a given time. Patients are financially responsible for any fees not paid by insurance for any of the following reasons: non-covered services, ineligible date of service, previous use of benefits, deductibles, co-payments, lack of proper referral, or providing our office with incorrect or incomplete insurance information.

Insurance Authorization: I hereby authorize New Hartford Eyecare to release any information needed to process an insurance claim, and for insurance benefits to be paid directly to New Hartford Eyecare. I understand and agree to the above credit and payment terms.

Patient/Guarantor signature _____ Date _____

Patient/Guarantor name printed _____

MEDICARE ONLY

1. \$155.00 yearly deductible: According to Medicare rules, the first \$131.00 in total fees from all doctors each year must be paid by the patient. If we receive a notice from Medicare that you have not met your deductible, we are required by Medicare to bill you for any portion of the deductible that has not been met.
2. After you have met your deductible, Medicare will cover 80% of the “eye health exam” if Medicare determines the service to be reasonable and necessary; otherwise Medicare will deny payment, which will result in you (the patient) being financially responsible for services rendered.
3. Secondary Insurance: Please notify our office and Medicare if you have secondary insurance, or if Medicare is not your primary insurance. After we receive a statement from Medicare, we may bill secondary insurance for you. If you do not have secondary insurance, you will be billed for the remaining 20% of the Medicare allowable fee in addition to any part of your yearly \$131.00 deductible that has not been met. If you are submitting an insurance claim yourself, attach a copy of our fee slip. Payment is due 14 days after the bill is mailed to you, regardless of whether your secondary insurance has reimbursed you.
4. Refraction: Medicare will not pay for the refraction (test for eyeglass prescription). The refraction fee is \$32.00 when performed along with an eye health exam in our office. If you have recently had an eye health exam (such as soon after cataract surgery) the doctor may determine that only a vision exam (for eyeglass prescription) is necessary, which cannot be billed to Medicare. Fee is \$40.00 for a new patient, \$35.00 for an established patient.
5. Optomap Retinal Photography: When used as a routine screening procedure it is not covered by Medicare, and the patient is responsible for the fee of \$35.00. If it is used to document and monitor a known disorder of the retina or glaucoma, an Optomap Plus high resolution photo can be billed to Medicare.
6. Medicare eyeglasses: are covered ONLY after cataract surgery. See Optician for details.

I understand all above information regarding Medicare, and agree to these policies. I authorize New Hartford Eyecare to release any information necessary to the Health Care Financing Administration in order to process a claim, and for Medicare payments to be made directly to New Hartford Eyecare.

Patient name _____

Signature _____ Date _____