THE EYE CENTER LLC.

61 Lincoln St Ste 305, Framingham, MA 01702

PATIENT'S NAME: _____
LAST FIRST MIDDLE

ADDRESS: **CITY:** **STATE:** **ZIP:**

DATE OF BIRTH: **SEX:** (circle one) FEMALE MALE

PHONE# HOME: **WORK:** **CELL:** **EMAIL:**

PRIMARY CARE PHYSICIAN (PCP) NAME: **PCP PHONE:**

RACE: (circle one) WHITE/BLACK/ HISPANIC/ASIAN/ OTHER/ "REFUSE TO REPORT" **ETHINCITY:** Hispanic/NOT Hispanic/"REFUSE TO REPORT" **LANGUAGE:**

If the Insurance is NOT in <u>your name</u>, then only fill the section below

INSURED PERSON'S NAME: _____
LAST FIRST MIDDLE

ADDRESS: **CITY:** **STATE:** **ZIP:**

Insured Person's MEMBER NUMBER (also called Member ID/Policy/Contract on the Insurance card):

Insured Person's DATE OF BIRTH: **SEX:**(circle one) FEMALE MALE

PHONE# HOME: **WORK:** **CELL:** **EMAIL:**

PATIENT RELATIONSHIP TO THE INSURED PERSON: (circle one) SELF SPOUSE CHILD OTHER

<u>PLEASE READ THE FOLLOWING CAREFULLY:</u>

If you have a co-pay, **Full CO-PAYMENTS are required NOW**.
As a courtesy to you, we will bill your insurance company for payments for your treatment; however **we will need <u>your</u> cooperation** in collecting the payments from them. Please respond to requests for additional or corrected information from our staff in a timely manner.

<u>Referral</u>: I understand that in order to cover the cost of my services, a **prior authorization** or **referral from my primary care physician** (PCP) may be necessary. I also understand that **I am responsible** for getting these authorizations or referrals and if The Eye Center does not receive written authorization or referral from my primary care physician <u>prior</u> to being seen by a physician at the Eye Center, and the claim is denied by my insurance company, **I will be held financially responsible and pay for any and all charges incurred,** regardless of the reason.

<u>Annual/Routine Eye Exam</u>: I also understand that if my Insurance covers an "Annual/Periodic Eye Exam", the doctor is the <u>sole decision maker</u> on whether the visit is classified as a "routine" or a "medical condition" based on the doctor's exam, The Eye Center, at its discretion, may bill it out as an "Office Visit" which may incur copayments, deductibles etc. which I will pay for when billed. Further, this "Eye Exam" may require a referral from my PCP which **I will obtain** from my PCP when asked by The Eye Center. Please do not call us after the fact disputing the classification; we <u>will not</u> be able to reclassify the visit.

I understand that by providing my contact information, email and phone numbers (including cell phone), I authorize The Eye Center or its service providers to contact me at those numbers or addresses for any medical, billing/collections or other helpful information.
<u>Authorization</u>: I hereby authorize The Eye Center LLC to submit a claim to my insurance carrier or the intermediaries for all services rendered by The Eye Center LLC and direct my insurance carrier or its intermediaries to issue payment check(s) directly to The Eye Center LLC. I hereby authorize The Eye Center LLC to release all information necessary regarding services rendered to my insurance company and referring physician.

<u>FINANCIAL POLICY:</u> I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER THEY ARE PAID OR NOT PAID (Completely or Partially) BY MY INSURANCE COMPANY DUE TO ANY REASON.
Unpaid accounts 60 days old are considered delinquent and will be **automatically** sent for collection actions by our computer systems

By signing this form, I agree that a) **ALL** the information set forth in this form <u>and the insurance cards I provided</u> are accurate and complete b) The Eye Center will be entitled to recover any and all costs of collection including reasonable attorney fees, collection agency fees, and any other related expenses incurred for any outstanding balance. The laws of the Commonwealth of Massachusetts will apply and I hereby submit to the jurisdiction of said courts. I agree to pay interest on any unpaid balances, beginning 30 days after the date of service, at the rate of 1.5% per month; 18% per annum, or the maximum judicial rate, whichever is less.
I agree to pay **$35.00** for each check issued by me which is returned to The Eye Center unpaid or marked NSF. I also agree to pay a service fee of **$10.00** for any unpaid balances submitted to collections.
I acknowledge that I have read and agree with The Eye Center's HIPAA Privacy policy (on the back of this clipboard) or on the web at <u>http://eyecenterllc.com/hipaa</u>

Patient Signature: _____ Date: _____

☺ THANK YOU !

10/1/2012