Date_____ Precision Family Eyecare, P.C.

Patient Information

Last Name_____First Name_____MI_____

I Prefer to be Called:_____Male / Female (Circle One)

Social Security Number_____Date of Birth_____

Mailing Address_____

Street Address_____

Home Phone_____Cell Phone_____

Work Phone_____Email address_____

Primary Doctor_____
Name Phone

Who Referred you to our office?_____
(Name of physician, friend, yellow pages, insurance list, etc)

What is the major purpose of your visit today?_____

Patient Insurance Information

In order to ensure accurate insurance information, we require your current insurance cards to scan.

*Primary Insurance CO Name_____

Policy Holder Legal Name_____ Policy Holder DOB_____

*Secondary Insurance CO Name_____ Policy Holder DOB_____

Policy Holder Name_____ Policy Holder DOB_____

Person Responsible for Patient

Name_____DOB_____SSN_____

Mailing Address_____
Street or PO Box City State Zip

(Signature required on back of form)

Lifetime Signature on File, Assignment of Benefits, Financial Agreement

We are committed to providing you with the highest level of service and quality care.
We expect, in turn, that you have the same commitment to your financial responsibility to us.

1. **Medicare:** I request that payment of authorized Medicare benefits be made on my behalf to **Precision Family Eyecare, P.C. or Grant Schaneman, OD (collectively referred to as PFE)** for services furnished me by FPE. I understand my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. Coinsurance and deductible are based upon the final determination of the Medicare Carrier and are my responsibility.
   Medicare Advantage Plans: I agree to provide appropriate information regarding my Medicare Advantage Plan to PFE as this may affect coverage for services provided. If I fail to provide accurate and timely information to PFE, I agree to be fully responsibility for payment.
2. **Supplemental Insurance:** With current information, PFE will file my supplemental insurance claim on my behalf. My signature below authorizes release of the information to the insurance company. I request that payment of authorized secondary insurance benefits be made on my behalf to PFE. If my supplemental insurance plan pays me directly, I agree to remit said payment immediately to PFE.
3. **Release of Information:** PFE may disclose all or any part of my medical record and/or financial ledger to any person or corporation which is or may be liable or under contract to PFE for reimbursement for services rendered, and to any health care provider for continued patient care. A copy of this authorization may be used in place of the original.
4. **Other Insurance:** PFE participates with most major insurance plans and vision plans and will make a reasonable effort to notify me if PFE has no contract, expressed or implied, with my particular insurance plan. Notification may be verbal or by signage. However, it is ultimately my responsibility to understand my insurance plan's coverage, benefits and limitations. I agree to be responsible to all items or services rendered by PFE regardless of insurance coverage, and I accept full financial responsibility if incorrect or untimely insurance information is given by me to PFE.
5. **Non-Covered Services:** I understand that PFE contracts with insurance plans relate only to items and services which are covered by the insurance plans, and that FPE does not determine what defines a covered benefit on my insurance company and cannot make any guarantees about coverage. That determination is made only by my insurance plan after the claim is received. Accordingly, the undersigned accepts full financial responsibility for all items or services which are determined by the health care service plans to be non-covered. Examples of non-covered items my include services considered to be routine, cosmetic, preexisting or experimental, and treatment or tests not recognized by the health care service plan.
6. **Financial Agreement:** I agree that in return for the services provided to the patient by PFE, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to PFE for payment. Copays not paid at the time of services are subject to a $10.00 billing fee. Repeat statements are subject to a $10.00 billing fee. **Minor Children:** PFE is not party to any divorce or custody arrangement, therefore the parent accompanying the minor child is responsible for payment. **Collections:** If an account is sent to a collection agency, I agree to pay all collection expenses and reasonable attorney's fees as established by the court. I understand and agree that if my account is placed for collection, I will be charged a delinquent account fee based on my account balance as follows: for balances up to $100.00, the fee added is $25.00. From $101 to $500, the fee added is $50.00. From $501 to $1000, the fee added is $75.00. Delinquent account fee are not negotiable. Non-payment of accounts my result in termination from the practice. Account disputes must be received within 60 days of first statement date. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to PFE.

It is understood that the undersigned and/or patient are primarily responsible for the payment of my bill regardless of insurance coverage.

_____

Beneficiary or Authorized/Responsible Party Signature Date