Westside Eye Clinic
Patient Information/Registration

Acct#_____

Please Print – Fill in all blanks
Patient's Name: _____ SS#: _____
Patient's Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone #: _____ Cell Phone #: _____
E-Mail Address:_____
Sex: M F Marital Status: _____ Birth Date: _____ Age: _____
Primary Physician: _____ Referred By: _____
Patient's Employer: _____
(or Parent's Employer, if patient is a minor)
Employer's Address: _____
Work Phone #: _____ Occupation:_____
Spouse's Name: _____ Spouse's Employer: _____
In case of emergency who should we notify:
Name: _____
Phone #: _____ Relationship:_____
If patient is a minor, please complete the following information:
Responsible party: _____ Phone #: _____
Address: _____
Relationship to patient: _____Parent _____Legal Guardian _____Other

Primary Insurance Information
Name of Insurance Company: _____
Address: _____
Policyholder's Name: _____
Policyholder's SS#: _____ Policyholder's Birth Date: _____
Policyholder Employed By: _____
ID/Policy #: _____ Group #: _____

Secondary Insurance Information
Name of Insurance Company: _____
Address: _____
Policyholder's Name: _____
Policyholder's SS#: _____ Policyholder's Birth Date: _____
Policyholder Employed By: _____
ID/Policy #: _____ Group #: _____

With the exception of patients with Medicare and/or an HMO or PPO insurance plan for which we are participating, payment is due at the time the service is rendered.

Payment for co-pays, co-insurance, deductibles and non-covered services are due at the time of service.

I understand that I will be responsible for payment of services not covered or payable by Medicare, my HMO or PPO or my employer for a work-related injury and agree to pay for these services. I further understand that should it become necessary to refer my account to an attorney for collection, I will be responsible for all reasonable attorney fees and court costs incurred in collecting payment on my account.

A refraction, the exam to determine eyeglass prescriptions, may be performed during your visit. This exam is separate from the comprehensive eye exam and may not be covered at Westside Eye Clinic by your insurance plan. The fee for the refraction is $30.00 and payable at the time of service.

Contact lenses are to be paid in full at the time the lenses are dispensed. A deposit of one-half of the fee is required prior to ordering “special order” lenses and is non-refundable. A fee for the fitting of contact lenses will be assessed in addition to the fee for the lenses and is payable at the time of service.

I hereby authorize release of medical information or other information necessary to process claims for services rendered to me by the physicians of Westside Eye Clinic. I also authorize release of medical records requested by my insurance company for quality assurance purposes.

I hereby authorize payment of Medicare, insurance and any other claims for services rendered to be made directly to Westside Eye Clinic.

Signature: _____ Date: _____

WESTSIDE EYE CLINIC

REFRACTION POLICY

1. What is a refraction?

Refraction is the procedure in which we determine the best corrected visual acuity of each eye for purposes of medical evaluation or for prescribing glasses, contact lenses, or corrective surgery.

2. Why is it sometimes necessary?

Refraction is sometimes necessary depending on the patient's diagnosis and/or complaints presented that day. For example, if a patient is experiencing blurred vision or a decrease in visual acuity on the eye chart a refraction would be needed to see if this is due to a need for glasses or due to a medical problem. A refraction is also necessary to prove to insurance the need for cataract surgery. We must prove that your vision cannot be simply improved with a glasses prescription. As you can see a refraction is an essential part of an eye exam, however, Medicare and most insurance do not cover it.

3. How much is it?

If the refraction is a non covered service with your insurance, our office policy is to charge $30.00 for this procedure in addition to the office visit copay and/or deductible. This is due at the time services are rendered.

Note: This fee is due and payable whether or not you receive a written glasses prescription. Sometimes the change is not significant enough to warrant the cost of purchasing new glasses and new prescriptions will not be given.

ACKNOWLEDGEMENT

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The copay and deductible are separate from, and not included in, the refraction fee.

_____ _____

Patient signature (Parent for minor) Date