Kartesz Eye Care Patient Information

Last Name: ______________________________________ First Name: _______________ MI:___ Date: ___/___/___

Address:___________________________________ City_______________________ State_______ Zip______________

Date of Birth: ___/___/___ Sex: M F Social Security #:_______________________ Marital Status: ______________

Employer: ____ Work Phone: ______________________________________

Home Phone: ____________________ Cell Phone: ___________________ Email: ______________________________

Medical Insurance Plan: ____ ID#:______________________________

Policy Holder Name: _____________________________ Policy Holder SS #:_____________________ DOB___/___/___

Vision Plan: _____________________________________ ID#:____

Policy Holder Name: _____________________________ Policy Holder SS#::____________________________________

Medications You Currently Take: ____

Financial Policy: Initial and Sign Below

__ **Payment** is due at the time of service. All co-pays, non-covered services, co-insurance amounts and materials deposits are due at the time of service. A current ID and Insurance card must be presented at the time of service.

__ **Referrals** must be requested by the patient from their Primary Care Provider and brought to the office at the time of service. Patients receiving services without appropriate referrals will be responsible for payment at the time of service.

__ A **collection fee** of 33 ½ % will be added to balances due and forwarded to collection. Legal fees and other associated fees will be the responsibility of the patient.

__**Materials** (Eyeglasses or contact lenses) not picked up within 90 days of notification will be returned to stock. All deposits are non-refundable.

Our office participates with both medical and vision plans. In the event that your exam is billed medically and there is a remaining balance, we will first exhaust your vision plan benefits before transferring any balance to your account. I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to Kartesz Family Eye Care and the physician providing services today.

Patient Signature: ____ Date: ___/___/___

HIPAA Acknowledgement Receipt: The offices of Kartesz Family Eye Care have provided me with a copy of their HIPAA Policy. Patient Signature: ____ Date: ___/___/___

Wellness Screening: Our practice offers wellness retinal photos, this technology can detect conditions such as diabetes, glaucoma, macular degeneration and the overall health of the eye. This test is quick, painless and may not require dilation drops. This test is $20.00 and will be reviewed with you by your doctor during today's visit.

___ Yes, I would like the doctor to provide this test today.

Patient Signature: ____