Prado Vision & Lasik Center

PATIENT REGISTRATION

Date_____

Name_____ M ❑ F ❑ Age _____

Address _____

City_____ State_____ Zip_____ Phone _____

Date of Birth _____ Social Security # _____

Marital Status _____ Referred By _____

Employer _____ City_____ State _____

Business Phone _____

Spouse's Name _____ DOB _____

Spouse's SS# _____

Spouse's Employer _____ City_____State _____

Business Phone _____ Cell _____

If Under 18

Father's Name _____ DOB _____

SS# _____ Employer _____

Work/Cell Phone _____ Home Phone _____

Mother's Name _____ DOB _____

SS# _____ Employer _____

Work/Cell Phone _____ Home Phone _____

Family Physician _____ Phone_____

NOTICE OF PRIVACY PRACTICE

We, at **Prado Vision & Lasik Center**, are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our **HIPAA Compliance Officer** in person or call our main phone number, 931-0500.

REQUEST TO SHARE MEDICAL INFORMATION

I,_____, hereby authorize the following person or persons to speak to Prado Vision and Lasik Center regarding my care, treatment, diagnosis and prognosis. Please note that information will not be discussed with anyone other than those listed below.

Name: _____Phone Number: _____

Relationship to Patient: _____

Name: _____Phone Number: _____

Relationship to Patient: _____

Signature below is only acknowledgement that you have received this Notice of Privacy Practices:

Patient Signature: _____Date: _____

Witness Initials:_____

Our Financial Policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance. For your convenience, we accept cash, check, Visa, MasterCard, Discover and debit cards.

2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. It is the patient's responsibility to know his or her insurance benefits. As a courtesy to you, we will file your insurance claim if you assign the benefits to the doctor - in other words, if you agree to have your insurance company pay the doctor directly. It is your responsibility to contact your insurance company to resolve any nonpayment issues. If your insurance company does not pay the practice within ninety (90) days or denies payment, payment will become your responsibility. If we later receive a check from your insurer, we will refund any overpayment to you.

3. For HMO, PPO, or other managed care networks in which we participate, our policy is that all co-payments, deductibles and other non-covered health care services and supplies be paid at the time of service.

4. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. There will be a $10.00 statement fee added to your outstanding balance for all statements mailed excluding the first statement.

5. There will be a $25.00 returned check fee on all returned checks.

6. If your account remains unpaid, you will be responsible for all attorney, collection fees and charges incurred to collect this debt.

7. Please be aware that performing a **refraction** (the testing of vision where a series of lenses are presented to the patient to determine which provides the sharpest, clearest vision) is not a covered benefit under many insurance plans, including **Medicare. Our refraction fee is $40.00 and is due at time of service.** Additionally, we do no bill any insurance carriers, other than those with which we are contracted, for contact lens fits, supplies or glasses. Payment is due at time of service.

Cancellations

We know that there will be times when you will not be able to keep the appointments that you scheduled. We only ask that if this occurs you call us at least 24 hours in advance so that we can provide your appointment slot to another patient. **If you fail to notify us and fail to keep your appointment, you will be charged a "no show" fee of $25.00.**

Referral Authorization

Please note that is important that you bring your insurance card(s) and any Referral Authorization information required by your insurance company. If you are not sure whether a Referral Authorization is required, contact your insurance company prior to your visit to our office. Patients who do not obtain the proper Referral Authorization prior to the office visit will be required to reschedule their appointment or pay in full for all services rendered at the time of service.

I authorize the release of all medical and insurance related information to the Health Care Financing Administration, it's agents, and/or any other insurance carriers, as needed to determine benefits or process claims for the physicians of **PRADO VISION AND LASIK CENTER.**

I permit a copy of this authorization to be used, as needed, in place of the original, and I request payment of Medicare and/or other medical insurance benefits be made to **PRADO VISION AND LASIK CENTER**, on my behalf for services rendered.

I am responsible for all financial obligations of health services for the above patient.

_____

Signature of Patient (or responsible party, if minor) Date