Welcome to Envision Eyecare

PATIENT INFORMATION

First Name _____MI ____ Last Name _____ Called Name_____

Address _____ ☐ Home Phone_____

City _____State_____Zip_____ ☐Work Phone_____

Date of Birth _____ Gender: M / F ☐Cell Phone_____ ☐ Texting OK

SSN _____ ☐E-mail _____

Student: FT / PT Employed: FT / PT ⇧ **Please check preferred communication method**

Employer _____ Occupation _____

Marital Status: Single / Married / Other Spouse's Name_____

How did you hear about us? _____ If referred, whom may we thank? _____

Responsible Party (if patient is under 18): _____

Date of Birth_____ SSN _____ Phone_____

Address _____ City, ST, Zip_____

INSURANCE INFORMATION

VISION: _____

ID #_____Group #_____

Primary Insured: ☐ Self ☐ Spouse ☐ Other_____

MEDICAL: _____

ID #_____ Group #_____

Primary Insured: ☐ Self ☐ Spouse ☐ Other_____

If not self, Primary Insured's information:

Name _____ Date of Birth_____ SSN_____

Address_____ City, ST, Zip _____ Phone_____

OFFICE POLICIES

☐ Payment is requested for patient's responsibility of *Doctor Services* on the day of your visit.
☐ Payment is requested for patient's responsibility of *contacts* at the time of ordering.
☐ Payment is also requested for *half down* of patient's responsibility of *glasses* when ordering and the remaining balance before picking them up.
☐ All sales are final.

We will submit charges to your insurance carrier when complete information has been received. If insurance payment is delayed over 45 days, you will be expected to pay the balance. We will make all efforts to resolve issues for non-payment from your carrier. Any payments received from your insurance carrier after you have paid will be refunded to you immediately upon receipt of overpayment. All disputes of coverage with the insurance company are your responsibility to resolve.

I have read and understand all policies listed above. I understand that I am responsible for payment in full for all charges from this office regardless of insurance coverage. I hereby authorize my insurance benefits to be paid directly to Envision Eyecare. I am financially responsible for non-covered services and understand that payment is expected at time of service.

I acknowledge that I was given an opportunity to review Envision Eyecare's Notice of Privacy Practices.

I agree to receive messages from this office at any phone numbers listed in my chart.
I agree to receive written reminders and bills at the address listed in my chart.

_____ _____ _____

Print patient name **Signature of responsible party** **Date**

Envision Eyecare
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Fax: 406-549-8486
E-mail: envisionmissoula@gmail.com

Financial Policy, Medical Disclaimer, HIPAA

Financial Policy

• Payments are due at the time of service. Payments for glasses orders may be split into two payments - the first being due at the time of order- and second, due at time of pick-up. ***Glasses not fully paid on will remain in office from time of arrival for six months, if the balance remains unpaid, the glasses will be recycled, and down-payment will not be refunded.*** Contact lenses must be paid in full at the time of order.
• Prescription changes will be performed at no charge for 60 days following the original date of service.
• **ALL SALES ARE FINAL**. Many frames are under warranty and may be replaced for manufacturer's defects if the warranty is good. Once an order is sent to the lab, it may not be cancelled.
• Fees for services rendered are non-refundable.
• A complete eye exam AND contact lens fitting must be performed each year to maintain a current prescription for contact lenses.
• Three (3) contact lens follow-up appointments are included with the fitting fee. Each additional follow-up will be billed at $45.00.
• Open boxes of contact lenses may not be returned or exchanged.
• Patients who choose to reuse their own frames assume the risk of breakage or loss during production.

Medical Disclaimers

• By signing below, I acknowledge that refusing a retinal examination (dilation or Optomap) that the doctor will not be able to do a thorough health examination of my eyes and also may not be able to diagnose possible vision - or life-threatening disorders without this examination.
• I understand that choosing to have my eyes dilated carries a minimal risk of acute angle closure.

Notice of Privacy Practices

• I acknowledge that I have received and been given the opportunity to review the financial and privacy policies of Envision Eyecare.

_____
Patient Name (Please Print)

_____
Patient/Guardian Signature

Date _____