Ophthalmic Consultants *of* Rockland

COMPLETE BOTH SIDES

REGISTRATION

Acct. #: _____

Entered by: _____

Referral required ☐ YES ☐ NO

GENERAL

Patient Name: _____
LAST NAME FIRST NAME MIDDLE INITIAL

Birth Date: ___/___/___ SS #: ___-___-___ Home Phone: _____

Address: _____ Cell Phone: _____

_____ OK to text cell phone ☐ YES ☐ NO

City: _____ State: _____ Zip: _____ Email: _____

Sex: M ☐ F ☐ Who referred you to this office: _____

Government regulations require medical offices to ask the following questions: Language: _____ Race: _____ Ethnicity: _____ Refused ☐

Primary Care Physician: _____ Physician Phone: _____

Pharmacy: _____ Town: _____ Pharmacy Phone: _____

INSURANCE

Primary Insurance: _____	Secondary Insurance: _____
Address: _____	Address: _____
_____	_____
Policy #: _____ Group #: _____	Policy #: _____ Group #: _____
Policy Holder Name: _____	**Policy Holder Name:** _____
Birth Date: ___/___/___ **SS #:** ___-___-___	**Birth Date:** ___/___/___ **SS #:** ___-___-___
Patient Relation To Insured: _____	**Patient Relation To Insured:** _____

224-ALL-814001-0005

PAYMENT AUTHORIZATION

I authorize payment of medical benefits to Ophthalmic Consultants of Rockland, MD, PC, for services rendered.

I authorize this office to furnish my insurance carriers with any information relevant to my claim, and to make direct payment when accepted.

_____
Signature

_____
Date

MEDICARE RELEASE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Ophthalmic Consultants of Rockland for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

_____
Signature

_____
Date

TREATMENT WAIVER

I agree that if Ophthalmic Consultants of Rockland treats me or my child and I do not obtain the required referral form, properly dated, then I will be responsible for payment of these charges and can be billed directly.

I also understand that certain examinations, including **refraction** (vision testing for glasses), may be a **non-covered service** by my insurance company. Such charges will be my responsibility and may be non-reimbursable by insurance.

_____
Signature

_____
Date

Ophthalmic Consultants *of* Rockland

Financial Policy

Thank you for choosing Ophthalmic Consultants of Rockland, a specialty practice for your eye care needs. We are committed to providing you with excellent service in every area including billing and insurance claims filing. Please read and sign our policy below.

Our practice participates in many medical insurance plans. We do not participate in any vision plans. If your plan does not cover services provided by our physicians, payment in full is expected at the time of your visit. We accept cash and checks for co-pays.

We will bill your primary insurance company on your behalf for any medical services provided by our office. As a courtesy, we will also bill your secondary insurance company, though ultimately you are responsible for all balances identified by your insurance company. It is also your responsibility to provide us with accurate insurance information, referrals or other authorizations necessary for your visit, as well as accurate personal information which will allow us to be reimbursed for your services from your insurance company. Your insurance coverage is a contract between you and your insurance company and we cannot always fully anticipate, based on your individual contract, your full financial responsibility for your visit. We do realize that temporary financial difficulty may affect the timely payment of your account. It is your responsibility to contact us promptly if you need to set up a payment plan to satisfy a balance with us.

Our eye examinations typically consist of covered components in which we are assessing the medical health condition of your eyes. Refraction, in which an eyeglass prescription may be given in order to allow you to see more clearly, is usually a non-covered service. Most insurance plans, including Medicare, generally do not pay for refractions. You will be asked to pay for the refraction at the time of your visit. This fee is in addition to any co-pay, co-insurance or deductible balances you may have. Contact lens fittings and adjustments are non-covered services and will be billed separately.

If you are having surgery, we will assist in getting pre-certification or prior approval for your procedure. We will inform you in advance of the procedure if there are components which your insurance provider has not approved.

Charges you may be responsible for include but are not limited to:

1. Any services applied to your deductible or for which you are required to pay co-insurance and/or any co-pays as determined by your primary insurance carrier.
2. Care not covered because you have not obtained a referral from your primary care physician in advance of your appointment.
3. Care provided and not covered because of termination of your insurance.
4. Care provided and not covered because you did not provide accurate insurance information.
5. Fees for any services denied because they needed to be authorized in advance of treatment.
6. Care provided and not covered because the provider is considered out-of-network.
7. Care which is not covered by your insurance company. This includes, but is not limited to: refraction services in which an eyeglass prescription is obtained, contact lens fitting exams, contact lenses and various cosmetic services.

I have reviewed this financial policy of Ophthalmic Consultants of Rockland.

Patient's signature: _____ Date: _____