

Welcome

NOTICE OF PRIVACY PRACTICES

METHODS OF PAYMENTS

NO INSURANCE?

No problem. Children & Family Eye Care offers a discount for all non-insurance patients for Vision or Medical exam. Accept all major credit cards, Care Credit cash, or checks.

VISION PLANS

Some vision insurance plans do not provide an insurance card. Vision Plans are usually for allowance benefits towards glasses or contact lenses. Ex: VSP, EYEMED, AVESIS, SUPERIOR VISION, etc. **MEDICAL INSURANCES DO NOT COVER THESE BENEFITS. MEDICAID (SOONERCARE) ALLOWS GLASSES ONLY FOR PATIENTS UNDER 20 YEARS OF AGE. CONTACT LENSES ARE NOT INCLUDED.**

MEDICAL INSURANCE

Refractions (checking vision) & the contact lens portion of the exam are **not covered by medical plans**. We will file your insurance on you behalf, but this does not guarantee, payment and any balance will be paid by you. If deductible has not been met for the year, you will be responsible for services rendered. We keep this information on file because we perform medical eye care. We also use medial insurances for visits with infections, foreign body, eye disease, treatments, etc...

We're glad to answer any questions regarding your insurance benefits.

Thanks!

****PLEASE SIGN HERE- PRIVACY PRACTICES****

I acknowledge that I have read or have had the opportunity to read the Notice of Privacy Practices. (Available at the front desk)

Patient Name: _____

Date: _____

Signature of Patient or Guardian: _____

Welcome

Thank you for choosing our office for your needs. We're glad to help if you have any questions.
Please verify any new information with Reception. Thank You

All patient information is kept Confidential

Name: _____ Gender: M F Date: _____

Date of Birth: _____ Patient Social Security: _____

Primary Physician/ Pediatrician: _____

Insurance Information

ID Number/ Sooner care ID _____

Health History Please indicate if patient or family(blood relatives only) have any of the following:

Condition	Patient	Family	Condition	Patient	Family
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Macular Deg.	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Blindness	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Turned Eye	<input type="checkbox"/>	<input type="checkbox"/>

Other Health Condition: _____

Please indicate if any of the following conditions apply to patient:

Pregnant Allergies Drug Allergies Headaches Other _____

Please list all current medications: _____ none

Please list all allergic medications: _____ none

Your Eye Health and Vision is important to us:

Approx. Date of Last Eye Exam? 6 mos 1 yr 2 yrs 1st Exam

Planning to re-new Contacts or Glasses? Yes No Unsure

Payment Information

I authorize Children & Family Eye Care to bill my insurance for any applicable services or products, and I understand that payment for non-insured services are due the same day services are rendered.

Signature _____