Dr. Joseph Vincent
Dr. Justine Redlin

NP Intake 1

TREASURE STATE
EYE CARE

Patient's Name _____
First Middle Last

Age _____ Sex _____ Date of Birth ____/____/____ Patient's SSN # _____-____-_____

Mailing Address _____ City _____ State _____Zip Code_____

Primary Phone (____)_____

Occupation/Employer _____ Work Phone Number (____)_____

Marital Status (circle one) Single Married Separated Divorced Widowed

Primary Vision Insurance _____ Secondary Carrier _____
Responsible Party _____ DOB ___/___/_____ SSN# _____-____-_____

Primary Medical Insurance _____ Secondary Carrier _____
Responsible Party _____ DOB ___/___/_____ SSN# _____-____-_____

Treasure State Eye Care offers the ability to conveniently send appointment reminders, notify you when glasses and contact lens orders are ready to be picked up, and allow you the ability to communicate efficiently with our office via text messages and e-mail. Your information will only be used by this office for official business and will not be sold to marketers. This feature can be opted-out of at any time.
Cell Phone (____)_____ E-Mail_____

Do you have any member of your immediate family who, or has been, at patient of Treasure State Eye Care? If yes, please list them here: _____

How did you hear about Treasure State Eye Care? (please circle one): Family/ Friend _____

Yellow Pages Newspaper Sign Internet Facebook Instagram

Most insurance companies pay only a portion of your total charges. If you have questions on coverage, please contact your insurance company's representative. We can not guarantee the accuracy of benefit information given to us by the insurance company. Please understand that the financial responsibility of your account is yours, not your insurance company's. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits to the practitioner or supplier of services rendered or myself if the provider does not accept assignment. I understand that I am responsible for any balance that my insurance does not pay.
Signed: _____ Parent/Guardian: _____ Date: _____

Acknowledgment of Receipt of Privacy Practices
I Acknowledge that I received a copy of Treasure State Eye Care's "Notice of Privacy Practices.

Full Name (printed):_____ Signed _____ Date:_____

Treasure State Eye Care

Patient/Insurance Beneficiary Liability and Coordination of Insurance Benefits

Please read the following information regarding our billing, payment and insurance coordination policies. Many of our patients have both vision and medical insurance benefits, and we feel it is important that you understand what is covered, what may not be covered, and who is responsible for payment of your balance. Please feel free to ask any of our staff if you have questions regarding the following information.

Vision plans are designed to provide a "wellness" exam and typically only cover the determination of your glasses or contact lens prescription and a routine check up of a normal vision system. Vision plans are not designed to cover more advanced testing, treatment or follow up care for more complex eye conditions. Often times, vision coverage will have a lower fee and/or copay to represent this level of care.

When a medical condition, diagnosis, or complaint is present (including but not limited to diabetes, hypertension, dry eye, cataracts, or other eye disease), it will become necessary to bill your medical insurance for any service required. There are varying fees and billing levels associated with these services. Any copay you have for a medical specialist will be applied. Some components of the exam may not be covered, be applied to your deductible, or have a high copay. These values are determined by your insurance company and we cannot change or reduce their set fees. Many times, we do not know if your exam will be billed to your vision or medical insurance before we begin testing.

In some cases, it is possible to bill your vision insurance for the portion of the bill that your medical insurer deems you are responsible for. This is not true in all cases and does not cover all costs, but when applicable, we will provide your vision insurance with the required information for reimbursement.

All fees will be charged for services, special testing, and contacts or glasses as applicable. All fees are set and invariable, and a total cost will be provided at the completion of your exam. As services are irrevocable, and glasses are custom made, no refunds will be provided and all sales are final.

It is your responsibility to provide us with all of the information necessary to file a claim on your behalf. We care required to have copies of your current vision and medical insurance cards. We MUST be able to verify coverage before you will be seen, with the exception of ocular emergencies. If we cannot determine your coverage, payment will be expected in full at the time of service. We will provide you with the proper paperwork to bill your insurance company directly for reimbursement.

These rules are not determined by our office. Your insurance coverage is determined by and contractual with your insurance company.

Our best effort will be made to provide you with a timely statement of your account, insurances often take up to 90 days to provide us with this information. All balances are due within 14 days of the statement date, and all accounts over 120 days past due may be sent to a collection agency. I understand that should I default on payment of my account and collection agency services are required, all costs of collections up to 40% of the balance, including attorney/court costs will be added to the balance of my account.

I acknowledge that I have read and understand the billing policies at Treasure State Eye Care and agree to all terms and conditions therein.

Signed: _____ **Date:** ___/___/_____

TREASURE STATE
EYE CARE

Medical Information Release Form

Health Insurance Portability and Accountability Act (HIPAA) Release

Patient Name: _____ DOB: ____/____/_____

Please select one of the following:

[ ] I authorize the release of my eyeglass prescription, contact lens prescription, claims information, and also the pick up of my eyeglasses and/or contact lens products. Please list below anyone you may want us to release this information/products to:

_____

_____

_____

[ ] Information is not to be released to anyone

This Medical Information Release Form will remain in effect until the patient terminates in writing to Treasure State Eye Care

In case of an **Emergency**, please call:

Name: _____ Phone Number: (_____)_____

Signed: _____ Date: ____/____/_____