# WELCOME FORM
# BRENART EYE CLINIC

ID# (office use):_____

Patient Name (Print) _____     Date of Birth _____

I was offered a copy of Brenart Eye Clinic's Notice of Privacy Practices.   ❑ Yes     ❑ No

I authorize _____ (_____) to have access to my medical information and records.

                        Print Name                             Relation to Patient

## FINANCIAL POLICY

Thank you for choosing Brenart Eye Clinic as your eye care provider. We are committed to providing you with the best service possible. For that reason, we believe it is important for our patients to understand the difference between Medical and Vision Insurance. **Vision insurance** is designed to help determine a prescription for glasses/contact lenses, to help pay for glasses/contact lenses, and to cover a yearly routine evaluation of the health of the eyes. When a medical condition is present (e.g. Glaucoma, Diabetes, Macular Degeneration etc.), or when additional testing is needed related to a medical condition, we must file the visit to **Medical insurance (co-pays and deductibles will apply).** Vision insurance is not equipped to cover medical conditions, injuries, and/or treatments just like medical insurance is not equipped to cover routine eye care. Please understand that these are rules set by the insurance companies, and we are required to follow them.

We cannot always know prior to your appointment which type of insurance will be filed. We make every effort to be on a number of medical insurance carriers for your convenience, and if it is an insurance we accept then we will file those medical claims directly. **Please note that we are not able to take HMO insurances for medical benefits.**

The following statements further explain our Financial Policy. We ask that you read, understand, and sign at the bottom of this page.

1. All applicable co-pays and fees not billable to insurance are due at the time services are rendered.
2. Payment from insurance is to be paid directly to Brenart Eye Clinic. Primary Vision and Primary Medical insurers will be billed accordingly.
3. All benefits quoted are not a guarantee of payment by the billed insurance company.
4. If the patient does not have insurance, or proof of insurance (insurance card), payment is still due at time of service.
5. The undersigned will ultimately be responsible for any bill incurred in this office.
6. There will be a **$35.00** service charge on all returned checks and accounts over ninety **(90)** days old.

**Special note relating to refraction**:
Refraction is necessary in order to prescribe corrective eyeglasses or contact lenses. Most medical insurance plans, including Medicare, do **NOT** cover routine refractions or routine eye examinations (when no medical diagnosis is known or suspected).  Our office fee for refraction is **$35.00** and is collected at the time of service in addition to any applicable co-payments.

## EMAIL / TEXT CONSENT

**Patient Acknowledgment**:
By filling out the below information, I understand that my email address and cell phone number will be used for email and/or text appointment reminders, material notifications, special offers and patient surveys.

Email Address: _____

Cell Phone Number: _____

## ADDITIONAL INFORMATION

The American Recovery and Reinvestment Act of 2009 require providers to request the following. Please feel free to choose "Decline to Answer" if you are not comfortable supplying this information.

1.) I am (Race)…
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ White
- ❑ Hispanic
- ❑ Decline to Answer

2.) I am (Ethnicity)…
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino
- ❑ Decline to Answer

3.) My preferred language is…
- ❑ English
- ❑ Spanish
- ❑ Other _____
- ❑ Decline to Answer

## SIGNATURE REQUIRED

The above information is true to the best of my knowledge.  I authorize my insurance benefits be paid directly to the Brenart Eye Clinic.  I understand that I am financially responsible for any balance.  I also authorize Brenart Eye Clinic or insurance company to release any information required to process my claims.

_____     _____
*Patient/Guardian Signature*                                              *Date*