WELCOME FORM
BRENART EYE CLINIC

ID# (office use):_____

Print Patient Name _____ Date of Birth _____

HIPAA INFORMATION

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

Authorized Person Print Name(s) _____ _____

FINANCIAL POLICY

Thank you for choosing Brenart Eye Clinic as your eye care provider. We are committed to providing you with the best eye care service possible. As part of your care, we will make the process of billing as effortless as possible. The following statements explain our Financial Policy. We ask that you read, understand, and sign the statement.

1. In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. All professional services and materials are charged to the patient.
2. Payment from my insurance is to be paid directly to Brenart Eye Clinic. I understand that the Primary Vision or Primary Medical insurers in my file will be billed as my primary insurance.
3. All benefits quoted to me are not a guarantee of payment by my insurance company.
4. If the patient does not have insurance, or proof of insurance (insurance card), payment is due at the time of service.
5. All applicable co-pays and non-covered services are due at the time of services.
6. The undersigned will ultimately be responsible for any bill incurred on this office regardless of insurance.
7. Accounts ninety **(90)** days old are subject to a **$35.00** collection fee.
8. There will be a **$35.00** service charge on all returned checks.

Special note relating to refraction:
Refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is necessary to write a prescription for glasses or contact lenses. Most medical insurance plans, including Medicare, do **NOT** cover routine refractions or routine eye examinations (when no medical eye problem is known or suspected). Your vision plan may assist you with your eye care needs that are not covered by your medical plan, please notify us if you have any vision coverage. Our office fee for refraction is **$35.00** and is collected at the time of service in addition to any co-payment your plan may require.

EMAIL / TEXT CONSENT

Brenart Eye Clinic is making greater use of email and text messaging to communicate with our patients. To help us provide you with the most prompt service possible, please provide your current email address and cell phone number below.

Patient Acknowledgment:
I understand my email address and cell phone number will be used for the sole purpose of information delivery/receipt with Brenart Eye Clinic. Brenart Eye Clinic may email and/or text me appointment reminders, material notifications, special offers and patient surveys.

Email Address:_____

Cell Phone #: _____

HOW WERE YOU REFERRED TO OUR OFFICE

❑ Previous Patient ❑ Ad ❑ Insurance ❑ Phonebook ❑ Location/Drive by ❑ Internet ❑ Dr. Referral

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*