Brockport Optometry, P.C. Office of Dr. Michael Raff

Insurance and Personal Information

Name_____Date of

Birth_____

Address_____ Last 4 of SSN

xxx-xx-_____ Home phone_____ Cell phone_____

Email_____ Employer_____ Position_____ **PT** or **FT**

Marital Status_____ Partner's Name_____ Medical Ins/Policy#_____

Vision Ins/Policy#_____ Name D.O.B and last 4 of SSN (if not self)

_____ Primary Care

Dr_____ Specialist(s)_____

Was your last eye exam here? **Y** or **N** If No, Where and When_____

Receipt of Notice of Privacy Practices, Terms and Conditions, Written Acknowledgement Form & Consent to Provide Treatment

I, _____, have had the opportunity to review the Notice of Privacy Practices of the optometry office of Michael L Raff OD and Brockport Optometry P.C. and have had the opportunity to obtain a copy of such notice.

I also hereby provide my consent to Michael L Raff OD and his staff to provide medical care within the limits allowed under the laws of the State of New York and consistent with the standards of care within the community. I also consent to the use of my health care information to allow for treatment, payment and health care operations related to my care.

Patient/Responsible Party Signature _____ Date_____

Office Financial Procedures

____ **(initial)** To minimize patient expenses, we request payment for professional services (including HMO co-payments) be made at the time those services are rendered. If frames, lenses or contacts are ordered a minimum 50% deposit is required. In the event that Brockport Optometry pursues civil remedies against me for the collection of my financial obligations for service rendered to me, I hereby agree to be responsible for reasonable collection and/or Attorney fees and to disbursements incurred by Brockport Optometry.

____ **(initial)** Insurance payment information is received from your insurance company by my staff. ***Insurance does not guarantee the accuracy of the information given to us via phone or website.*** You, as the insured, are ultimately the responsible party and need to be aware of what your coverage is. Please take the time to call your carrier so you can provide us with accurate information.

____ **(initial)** We receive an EOB (explanation of benefit) notice from your insurance company with their payment. You may receive a bill for an undercharged payment once we receive the insurance companies' EOB notice sent to us.

____ **(initial)** Procedures such as contact lens fitting, re-evaluation or ocular imaging are often not covered benefits from insurance companies. They often qualify for reimbursement through a health savings account.

____ **(initial)** Fees are due on the day services are rendered or a $10 billing fee will be applied. If you have a deductible for your insurance plan, you must meet that in full. If you are committed to optometric care and have financial difficulties, we will be happy to work out a payment plan.

____ **(initial)** If you are unable to keep an appointment we ask that you give the office at least 24 hours prior notice. If you have an appointment on a Monday we ask that you call the office no later than the Thursday prior. If you do not contact us within that time frame you will be charged a **$100 broken appointment fee**.

____ **(initial)** Please inform our clerical staff of any changes to insurance or personal information.

____(**initial**)Patient agrees to receiving communication via SMS/text messaging. If the patient does not want to Opt in to SMS/ texting leave blank.

Patient/Responsible Party Signature ____ Date ___________________________