EYECARE about YOU

3025 Noe Bixby Road; Columbus OH 43232
Office: (614) 837-3797
Fax: (614) 837-9494

WELCOME TO OUR OFFICE!

In order that we may better serve you, please fill in the following information completely.

Patient Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ____________________________________ Date:__________________

Address: ____________________________________ City: ________________________ State: _____ Zip:_____

☐ Male ☐ Female Home/Cell Phone: _____________________

Date of Birth: _____________ Work/Other Phone: _____________________

S.S.#: ________________ EMAIL:____

Name of Emergency Contact:____ Phone #:__________________________

This Person has Permission to Pick up Glasses/Contact Lenses Yes / No Can We Discuss Medical Info Yes / No

Name of Medical Insurance:____ ID #_____________________________

Name of Vision Insurance:____

Name of Employer Insurance Provided Through: ____

Employer Phone #: ______________________________ Insurance Contact Person: _____________________________

Secondary Insurance Provider: ____

How did you hear about our office: _________________________If by word-of-mouth, who? ____________________

PLEASE READ CAREFULLY

I agree to pay for any and all medical services I receive from the providers of this practice that my insurance company refuses to pay, for whatever reason. This office will file a claim in my behalf; however, if my insurance company denies payment for any reason (e.g. non-covered services, does not pay for preventative medicine services, my failure to secure a referral from my primary care physician), I will pay for same upon written/verbal notice of their refusal. Failure to pay within 45 days of filing is, for the purpose of this agreement, a refusal to pay.

Patient's Signature: ____ Date:____________________________

If <18 y/o Parent/Guardian Signature:____ Date:____________________________

Printed name of parent/guardian:____

PATIENTS WITH MEDICARE INSURANCE

Medicare will only pay for services it determines to be "reasonable and necessary" under Section 1862(a)(1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under the Medicare program standards, Medicare will deny payment for that service. It is believed that in your case, Medicare is likely to deny payment for the following service for the following reason(s):

_X_ Medicare does not usually pay for an eye examination or corrective eyewear.

BENEFICIARY AGREEMENT:
I have been notified by my medical provider that she/he believes, in my case, that Medicare is likely to deny payment for the services identified above for the reason(s) stated. If Medicare denies payment, I agree to be personally responsible for payment.

Signature: ____ Date:_________________________