NEVADA EYE PHYSICIANS

1505 Wigwam Pkwy Ste 100
Henderson NV 89074-8194
(702) 896-6043 WEBSITE

PATIENT INFORMATION			
NAME (LAST, FIRST, MIDDLE)	SSN#	BIRTHDAY	SEX
ADDRESS	HOME PHONE	CELL PHONE	
CITY, STATE, ZIP	EMAIL		
PRIMARY CARE PHYSICIAN	ETHNICITY	RACE	LANGUAGE
REFERRING PHYSICIAN			

EMPLOYER	
PRIMARY EMPLOYER	
ADDRESS	CITY, STATE, ZIP
WORK PHONE	

RESPONSIBLE PARTY FOR INSURANCE		
CHECK ONE BOX : ☐SELF	☐ SPOUSE ☐PARENT **(IF SPOUSE OR PARENT FILL IN BOX BELOW)**	
NAME (LAST, FIRST, MIDDLE)	SSN#	BIRTHDATE
ADDRESS	CITY, STATE, ZIP	RELATIONSHIP
PHONE NUMBER	SEX	CELL PHONE

PRIMARY INSURANCE		
NAME OF INSURANCE COMPANY	POLICY #	
NAME OF INSURED	GROUP #	DOB
ADDRESS	CITY, STATE, ZIP	
RELATIONSHIP TO PATIENT ☐SELF ☐ SPOUSE ☐PARENT	COPAY SPECIALIST	TESTING COPAY

SECONDARY INSURANCE			
NAME OF INSURANCE COMPANY	POLICY #		
NAME OF INSURED	GROUP #	DOB	
ADDRESS	CITY, STATE, ZIP		
RELATIONSHIP TO PATIENT ☐SELF ☐ SPOUSE ☐PARENT	PAYS DEDUCT ☐ YES ☐ NO	PAYS 20% ☐ YES ☐ NO	REFRACT COVERED ☐ YES ☐ NO

ACKNOWLEDGE RECEIPT OF NOTICE OF PRIVACY POLICIES

My signature below acknowledges the receipt of Nevada Eye Physicians ***Notice of Privacy Policies***

_____ _____ _____

Signature Date Social Security #

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FINANCIAL AGREEMENT

Dear Patient:

Thank you for choosing ***Nevada Eye Physicians*** *as your eye care provider*. The following is our Financial Policy which will help you with your concerns regarding our billing and payment procedures.

Payment for services is due at the time service is rendered. We accept cash, money orders, debit cards, credit cards. We will submit an insurance claim on your behalf. If your carrier is not contracted with our practice, we will courtesy bill them with the understanding that whatever the insurance does not pay; the balance is then your responsibility to pay within 30 days of your first billing statement. **IF YOU HAVE A CO-PAY, IT WILL BE COLLECTED AT THE TIME OF SERVICE. Please note that we do not submit co-pays to a secondary carrier. We will give you the appropriate information to do this on your own.**

You are responsible for knowing your insurance benefits. What are covered services in your plan? Does your insurance require a Primary Care Physician (PCP) referral? Does your physician participate in the plan? **If you are an HMO member, you are responsible for obtaining referrals/authorizations from your PCP and/or carrier.** Patients are responsible for deductible balances, co-insurances and **non-covered** amounts at the time of service. Any billed balances are due within 30 days of the statement date.

Please have **ALL INSURANCE CARDS** and a **PHOTO ID AVAILABLE FOR PHOTOCOPYING AT ALL TIMES.** Any changes of insurance, address, phone number or emergency contact information should be reported immediately.

We appreciate the opportunity to examine and care for your eyes. In the world of health insurance, Medicare and most other carriers will **NOT COVER THE REFRACTION AS PART OF THE EXAM.** This part determines whether your vision can be improved or not with glasses and is needed to dispense glasses or obtain approval for **ANY** surgery. **There is a $50 fee for the refraction testing due at the time services are rendered.**

Remember that insurance authorizations/referrals for services DO NOT guarantee payment. If the insurance does not pay in full within **60 days, we ask that you contact them as charges will be transferred to you.** We require you to pay the balance due even though your insurance carrier may eventually process your claim. A refund will be mailed to you. **Interest on past due balances will accrue at a rate of 1.5% monthly.** There will be a **$25.00** fee for all **returned checks. Should your account become delinquent and be referred to a collection agency, you shall be financially responsible for the costs of collection and/or legal fees.** Collection costs are calculated by adding the principle the greater of $25 or an amount 35% in excess of balance owed.

I request that payment of authorized Medicare/or any third-party benefits be made to **Nevada Eye Physicians** on my behalf for any services rendered to me. I authorize any holder of medical information about me to release to the Center for Medicare / Medicaid Services and its agents or any third party payor to determine these benefits or the benefits payable for related services.

_____ _____

Print Patient Name Patient/Parent/Guardian ***Signature***

_____ _____

Date of Birth **Date**

GUARDIANSHIP AND/OR HOSPICE CARE INFORMATION

Does someone have Power of Attorney or legal guardianship for you? ☐ Yes ☐No

Are you currently under in-patient or out-patient hospice care? ☐Yes ☐No

Of you answered YES, to either of thes questions, please provide us with contact information for the guardian and/or the hospice. Nevada Eye Physicians also needs a **copy of the POA or legal guardianship paperwork** if this applies.

Legal Guardian Name _____ Signature _____ Phone _____

_____ _____ _____

Name of Hospice Services Case Manager's Name Phone Number

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PATIENT CONTACT

Nevada Eye Physicians may contact you regarding appointments, test results, financial matters/billing concerns by telephone at any number associated with your account and leave a message as necessary. This can include a wireless telephone numbers, which could result in charges to you. We may also contact you by sending emails, if an email is provided to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automated dialing system if applicable.

My **PREFERRED METHOD OF CONTACT IS:**

Nevada Eye Physicians reminds our patients of their appointments by phone call, text message and email.

Voice Call ☐ Text Message/SMS ☐ Email:_____ Other☐

RELEASE OF PHI TO SPECIFIED PARTIES

Do we have permission to release your protected health information to anyone involved in your care? ☐ **YES** ☐ **NO**

If "YES", list the names(s) of the person(s) who has permission for access to your protected health information. We need the name, relationship, phone number and type of access.

Name		Name	
Relationship		Relationship	
Telephone		Telephone	
Information	All Records ☐ or	Information	All Records☐ or

I understand that my permission for the release of my protected health information to parties listed above will remain in effect indefinitely, unless revoked in writing.

_____ _____ _____

Print Patient Name Patient/Parent/Guardian ***Signature*** Date

Patient representative signature if patient is unable to sign:

_____ _____ _____

Signature Relationship Date

CONSENT TO OBTAIN MEDICATION HISTORY

A medication history is a list of prescription medicines that our practice providers or other providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this. The collected information is stored in our practice electronic medical records and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions. It is very important that you and your provider discuss all your medications in order to insure that your medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased with using your health insurance. Also over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

I give my permission to allow my healthcare provider to obtain medication history from my pharmacy, my health plans, and my other healthcare providers. This consent will remain in effect for three years.

_____ _____ _____

Print Patient/Parent/Guardian Patient/Parent/Guardian Signature Date

CULTURAL BACKGROUND INFORMATION AND PREFERRED LANGUAGE

The Federal Government requires that we ask the following questions to our patients. This is voluntary and has no impact on your medical eye care.

ETHNICITY Check One	☐Hispanic or Latino		☐Non-Hispanic or Latino
RACE Check One	☐American Indian or Alaskan Native	☐Asain	☐Black or African American
	☐Native Hawaiian or other Pacific Islander	☐White	☐Other
	☐I prefer not to answer		
LANGUAGE	☐ENGLISH	☐SPANISH	☐OTHER _____

If English in NOT your primary language, would you say you speak English:

☐**Very Well** ☐**Well** ☐**Not Well** ☐**Not at All**