Advanced Eye Care, SC
Patient Registration Form

(Please print and complete all entries.)

Patient Name (First-MI-Last)	Date of Birth	Circle Marital Status	Sex
		Single Married Divorced Widow	☐ Male ☐ Female

Parent/Guardian (if patient is a minor or dependant) First-MI-Last | Relationship

Street Address | City-State-Zip

Home Phone | Cell Phone | E-Mail

Who is financially responsible for payment? | Responsible Party's phone number

Please tell us how you heard about our office:

☐ Health Plan ☐ Website ☐ Facebook ☐ Referred by another patient

☐ Shopping Cart ☐ Local Ad ☐ Internet Search ☐ Other: _____

Referring Physician

Primary Care or Referring Physician | Primary Care or Referring Physician City

I certify to the best of my knowledge that the above information is correct. I hereby authorize release of information necessary to file a claim with my insurance company. I understand I am financially responsible for all professional services provided and for any balance not covered by my insurance carrier.

Authorization for Medical/Surgical Treatment: I consent to office care encompassing routine technical procedures and medical treatments performed by my attending physician, assistant, or designees, as may be necessary in my physician's best medical judgment. My consent is valid until revoked by me in writing and delivered to Advanced Eye Care, SC ("AEC").

I acknowledge receipt of the Practice's Privacy Practice. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I understand that AEC has reserved a right to change their privacy practices and that a copy of any revision will be available to me at my next visit following the revision. I understand my consent is valid until revoked in writing and delivered to AEC, and that I cannot revoke this consent in cases where AEC has already relied upon it to use or disclose my health information.

I understand that most insurance plans do not provide for routine eye care, including a refraction. A refraction is the test performed to identify my best corrected vision. The fee is $45 and is payable at the time of service. AEC will submit the charge for the refraction to my insurance. Should my insurance pay for the refraction, I will be refunded my payment.

If I am a Medicare Beneficiary, I request that payment of authorized Medicare benefits be made either to me or on my behalf to Advanced Eye Care SC for any services furnished to me by Advanced Eye Care SC. I authorize any holder of medical information to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____

OR

I am the parent or legal guardian of _____ [patient name].

Name [please print]: _____

Signature: _____ Date: _____

Advanced Eye Care, SC
Practice Financial Policy

Dear Patient,

This document explains our practice Financial Policy. Your signature is required to receive care.

We send monthly statements to inform our patients of any balances due. We expect that patient due balances will be paid upon receipt of our statement. In order to make it easier for our patients, we accept cash, checks, VISA, MasterCard, and Discover. All may be given as payment at the front desk or sent with statements.

For Self-Pay patients: We expect payment at the time of treatment for patients who have no insurance coverage or for those who have insurance with which we do not participate. We will do our best to give patients an estimate of charges the day ahead of their visit when we call to confirm their appointment. Before visits, we will expect payment of the actual charge by one of the methods listed above.

For Insurance patients: We require that patients bring their insurance card with them to each appointment in our office so that we can be sure that we have the correct insurance information on file. We will scan your card into our system if necessary. As a courtesy to our patients, we will file a claim with the primary and secondary plans. If the plan has a co-pay, payment is required at check-in for visits. When primary and secondary plans have paid their portion of the charge, the remainder will become the patient's balance. Any question regarding coverage, benefits, or payment for service provided is the patient's responsibility to resolve with their insurance carrier.

Returned checks will be charged a $25.00 service fee.

Any balance on a patient account, for any covered or non-covered service, that is 30 days old will be considered *due* and is the patient's responsibility to pay. Any balance on an account that is greater than 30 days old is considered *past due*. It is our policy to send two statements (at 30 and 60 days) and send one letter to patients before taking further action on the account. If there is no response following these efforts, the account will be placed with a collection agency. In the event of collection action, patient is responsible for all costs associated with the collection of the debt, including collection fees of 30% of the total owed when sent to collections, all court costs, filing fees, and attorney fees should this account require litigation.

Questions regarding this policy should be directed to the Practice Administrator at 815-485-2727.

I acknowledge that I have received and read the above and consent to the terms of this Financial Policy.

Name	Signature	Date

Credit Card on File Policy

Dear Patients,

Advanced Eye Care, SC has a policy requiring a credit card to be on file for each patient undergoing a surgery or in office procedure, as defined by the practice. Upon check-in, we will capture your card information with a card reader, much the same as any other credit card transaction. As with all transactions, office personnel will never have access to your card data. NOTE, there is no charge to your card until insurance has processed your claims and identified a patient balance due.

Alternatively, you may make a $250 cash or check deposit onto your account, to be held until all service billings have been adjudicated. We will use the deposit to pay any patient balance as it incurs. You will be issued a refund for any remaining deposit following the payment in full of all services. You will be billed for any additional amounts owed.

Following your service, your insurance company will process your claim, pay their portion, and notify us of the total patient responsibility. At that time, any patient responsibility will be charged to your credit card on file. If you disagree with the patient amount owed, it is your responsibility to contact your insurance carrier immediately.

It is your responsibility to ensure that the card you have on file is not expired or cancelled and has an appropriate amount of available credit. Please call our office immediately if you need to update your credit card on file. If your payment is declined, a $35 declined payment fee will be applied and a warning letter sent. If we receive no response within 10 days of the letter date, your account will be sent to a collection agency.

I, the undersigned, authorize Advanced Eye Care, SC, to charge my patient responsibility to the following credit card. I will be sent a receipt once the payment is made. If my payment is declined, a $35 declined payment fee will be applied to my account.

___AMEX ___VISA ___MasterCard ___Discover

LAST 4 DIGITS Credit Card# _____ Expiration_____/_____

PATIENT Name _____

Cardholder Name _____

Signature_____

Billing Address_____

Email Address_____

Signature_____ Date_____