WE DO NOT PARTICIPATE WITH VISION PLANS

PATIENT NAME_____

ADDRESS_____

CITY/STATE_____ZIP CODE_____

PHONE# **(HOME**)_____(**CELL**)_____

E-Mail Address_____

GENDER_____DATE OF BIRTH_____AGE_____

PRIMARY CARE DOCTOR
NAME/ ADDRESS_____

PARENT / GUARDIAN #1 NAME_____

ADDRESS_____

PARENT / GUARDIAN #2 NAME_____

ADDRESS_____

FINANCIAL INFORMATION – Please read carefully and check one:

WE DO NOT PARTICIPATE WITH VISION PLANS – MOST MEDICAL PLANS OFFER A **SEPARATE** VISION PLAN FOR ROUTINE/NON MEDICAL EXAMS

_____**SELFPAY** – PATIENTS WITH A MEDICAL/VISION INSURNACE PLAN WITH WHICH WE **DO NOT** PARTICIPATE

____**MEDICAL INSURANCE** – TO THE BEST OF MY KNOWLEDGE, THIS VISIT SHOULD BE COVERED BY THE MEDICAL INSURANCE COMPANY LISTED BELOW. ANY CLAIMS DENIED BECAUSE YOU DO NOT HAVE ROUTINE/ NON MEDICAL COVERAGE WILL BECOME THE PATIENTS RESPONSIBILITY

DEDUCTIBLES MAY APPLY TO MEDICAL EXAMS

PRIMARY INSURANCE INFORMATION

Yes, we have made a copy of your card, but your medical insurance card may not include the SUBSCRIBER name and DOB of SUBSCRIBER.

INSURANCE COMPANY_____

Subscriber_____DOB of Subscriber_____
(name of the person who is the policy holder)

Relationship to Patient_____

ADDITIONAL INSURANCE INFORMATION

INSURANCE COMPANY_____

Subscriber_____DOB of Subscriber_____

Relationship to Patient_____

WE DON'T PARTICIPATE WITH VISION PLANS

FINANCIAL POLICY

- Ophthalmic/ Optometric exams are provided for MEDICAL care, as well as, VISION care – your plan may only consider payment for MEDICAL care.
  Most medical insurance companies now offer separate vision plans that we DO NOT participate with. While your medical insurance company may state you have VISION, many fail to include that it is with a separate vision plan.
  We will not submit claims to your vision plan.

  MEDICAL – eye disease, eye injury, eye infection, medical complaints/symptoms, or a pediatric medical problem with eye, such as, amblyopia (lazy eye), strabismus (crossed eyes) or, another congenital medical issue with the eyes.

  VISION – difficulty seeing the eye chart from school or pediatrician screening, blurred vision with no medical cause, myopia, hyperopia, astigmatism, baseline exam, and at times, headaches.

- Many medical insurance plans now have a deductible to meet before they will make payment. You are responsible for any deductibles applied your office visits.

- A REFRACTION is done to determine whether an initial eyeglass prescription needs to be given or an existing prescription needs to be changed. This part of the exam is billed as a separate procedure with an additional charge. If the REFRACTION is not covered by your medical insurance company, you will become responsible for the payment.

If you have any questions, please ask BEFORE seeing the doctor.

Falsifying a diagnosis is insurance fraud. We will not falsify a diagnosis to meet your medical insurance plan requirements. Please DO NOT ask us.

By signing below, I acknowledge that I have read the above statements. I acknowledge I am financially responsible for all charges including any copays, deductibles, non-covered/denied services, or any charges not paid by my insurance company. I hereby assign all insurance benefits to which I am entitled, including Medicare and/or other insuranace plans to RONALD MNZTER MD PC. I authorize RONALD MINZTER MD PC to release all information necessary to secure payment of benefits. I authorize this signature on all insurance claims.

SIGNATURE RELATIONSHIP TO PATIENT DATE

RONALD MINZTER MD
PEDIATRIC OPHTHALMOLOGY

EDWARD KULBACK OD
OPTOMETRIC PHYSICIAN

PATIENT NAME_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
(ON BULLLETIN BOARD, IN WAITING ROOM – COPY AVAILABLE UPON REQUEST)

____ I HAVE READ THIS OFFICE'S NOTICES OF PRIVACY PRATICES, WHICH EXPLAINS HOW MY CHILDS MEDICAL INFORMATION WILL BE USED AND DISCLOSED. I UNDERSTAND THAT I AM ENTILED TO RECEIVE A COPY OF THIS DOCUMENT.

PATIENT PRIVACY QUESTIONNAIRE:

PLEASE LIST FAMILY MEMBERS OF OTHER PERSONS, IF ANY, WHOM WE MAY INFORM ABOUT YOUR CHILDS GENERAL MEDICAL CONDITION AND DIAGNOSIS

PLEASE LIST THE FAMLY MEMBERS OR OTHER PERSONS, IF ANY, WHO HAVE YOUR PERMISSION TO BRING YOUR CHILD TO OUR OFFICE

_____ (INITIAL) I AM FULL AWARE THAT A CELL PHONE IS NOT A SECURE AND PRIVATE LINE

CAN MESSAGES BE LEFT ON YOUR VOICEMAIL?

_____ YES _____ NO

CAN WE SEND RECALLS OR REMINDERS ON A POST CARD TO YOUR HOME ADDRESS?

_____ YES _____ NO

_____
SIGNATURE OF PARENT/GUARDIAN DATE

_____
PRINT NAME OF PARENT/GUARDIAN