

Greenberg Laser Eye Center Established Patient Update Form

Please fill in all of the information below for the patient being seen today.

Today's Date: _____

Name: _____ Date of Birth: _____

Marital Status: __ S __ M __ D __ W Name Change: __ Y __ N

Address: _____ City: _____ Zip: _____

Preferred Phone: _____ Work: _____ Other: _____

Cell Home

Cell Home

Email: _____ (We do not share your information)

*Emergency Contact Name: _____

*Emergency Contact Phone: _____ (Cannot be the same as above numbers)

*Relationship to Patient: _____

*I authorize Greenberg Laser Eye Center to release my records and any information to the above individual
____ YES ____ NO

Family Doctor: _____ City: _____
First Last

Rheumatologist: _____ Endocrinologist: _____

Neurologist: _____ Cardiologist: _____

Medical Insurance: __ Aetna __ BCBS __ BCN __ CIGNA __ Cofinity __ HAP HMO __ HAP Preferred __ Medicare
__ Medicare Plus Blue __ Priority Health __ Total Healthcare __ Total Healthcare HMO __ UMR
__ United Healthcare Other: _____

Primary Subscriber Name: _____

Date of Birth: _____ Employer: _____ Employer Phone: _____

Vision Insurance: __ BCV __ DAVIS __ Eyemed __ NVA __ Optum Health __ UMR __ VSP

Other: _____

Primary Subscriber Name: _____ *Last 4 digits of
SS: _____

Date of Birth: _____ Employer: _____ Contact Phone: _____

Signature: _____ (if under 18 parent or legal guardian)

FINANCIAL POLICY AND BILLING PROCESS GREENBERG LASER EYE CENTER

- **Copay, Co-insurance and Deductibles:** It is my responsibility to know what my copay, co-insurance and deductibles are, and my obligation to pay this at the time of service. If I am not able to pay my co-pay, deductible or co-insurance portion at the time of service my appointment may be rescheduled or subject to a \$15.00 fee.
- **No Show Appointments:** All appointments that are not cancelled within 48 business hours of the appointment time are subject to a \$40.00 fee. This \$40.00 fee must be paid before we can reschedule your appointment.
- **Refractions:** Refraction is the process of determining if there is a need for corrective eyeglasses. It is an essential part of an eye examination and necessary in order to write a prescription for glasses or contact lenses. Medicare and most medical insurances do not cover this service. I understand that I am responsible for this \$36.00 fee due at the time of service.
- **Contact lens fitting:** There is a \$120.00 contact lens fitting fee charge for first time wearers and a \$60.00 charge for an established wearer.
- **Insurance Coverage:** I acknowledge that the insurance cards I have presented are current and accurate.
- **Medical vs Vision:** Your **medical insurance** is billed if a medical condition is discovered during your examination.
 - Evaluation of an ocular disease you have been diagnosed with (e.g., glaucoma, cataract, corneal, or retinal disease).
 - A complaint such as redness, tearing, burning, or other pain or discomfort to the eyes.
 - A history of or new onset of floaters, flashes of light, or other visual disturbance.
 - To follow an existing chronic condition such as diabetes, corneal disease, dry eye syndrome, an autoimmune disease, or if you take high risk medications like Plaquenil.
 - If you are scheduled for additional testing such as visual field, OCT, or retinal photography.
 - If your visit requires a report to your primary care physician.
- **Participating Insurance Plans:** If GLEC is not a participating provider in my insurance plan, I will be responsible for filing my own claims and I will be responsible for paying in full at the time of service.
- **Non-covered Services:** I understand that some services may be considered non-covered services by my insurance plan. I understand that it is my responsibility to know what my insurance does or does not cover and I understand that I am financially responsible for paying all non-covered services.
- **Denied Charges:** I understand that some charges may be denied by my insurance carrier as investigational, experimental or not medically necessary and will not be paid by my insurance

carrier. I understand that my physician feels these services are needed whether my insurance carriers deems them payable or not and that I am obligated to pay for these services in full.

- **Returned Checks & Past Due Accounts:** Returned checks will be subject to collection charges of an additional \$25.00 with penalties and interest. All accounts are considered past due if not paid within 90 days of service. Past due accounts may result in collection turnover and subject to penalties and interest, or the refusal of future appointments until old balances have been paid in full. The practice does not accept post dated checks.
- **Surgery Charges:** The practice will make every effort to determine your insurance benefits and to relay to you what you will owe for surgery charges, please keep in mind that this is just an estimate. Please be aware that when surgery is performed, you may incur additional charges (in addition to the surgeon's fees) from the surgery facility, anesthesiologist, laboratory or radiologist.

X _____

Patient/Representative Signature

Date