



Insurance coverage can be very confusing and frustrating to both you and our staff. Because of this we ask that you please provide all insurance cards and coverage so that our staff can determine the most appropriate coverage for your visit. There are several types of coverage: medical insurance, vision Insurance, and vision discount plans. We will bill the most appropriate plan depending on your presenting symptoms, complaints and medical history.

Vision Plans - (Ex. VSP, VBA, Eyemed, Davis Vision, etc.)

Some of these plans pay part (or occasionally) all of the services and some are discounted fee only plans. Coverage includes a refraction to determine your eyeglass prescription and a screening for eye disease / disorders. Some may include coverage for contact lens services and / or glasses. The examination for contact lenses is optional and not part of the routine vision examination. There is an additional charge to be fit for contact lenses and it may or may not be covered by your vision plan - usually it will have an additional co-pay if it is covered. Vision plans do not cover medical conditions of the eye.

Medical Coverage - *what is a medical eye exam?*

If you are having a problem with your eyes other than a change in vision then your examination will be billed medically. Some medical problems could cause blurred vision. If the doctor finds that a medical condition is causing your vision problem, then your examination will be billed medically. Many pre-existing conditions such as cataracts, glaucoma, diabetes, dry eye, etc. will require a medical examination. If your medical insurance requires a referral than it is your responsibility to obtain one before we will treat you.

****Some Medical Insurance plans do provide a annual wellness eye examination.**

Companies such as Horizon - NJ Direct, Aetna, Amerihealth, and others **may** provide a routine refraction and eye health screening. If you also have a vision plan it will be at our discretion as to which plan gets billed for the examination. We will consider the complexity of your exam, as well as insurance company rules and regulations to determine which plan will be billed. Your vision insurance plan or the discount plan will be used for any eyewear that you purchase.

Why is this so complicated? We ask ourselves this same question daily! We are legally obligated to follow the rules and regulations set forth by your insurance company and the state.

Confused? We will try to answer any questions that you may have about your insurance coverage, but you may need to consult with your insurance company or human resources department. Remember, your insurance is a contract between you the subscriber, and your insurance company. There are hundreds of insurance companies and plans and we are not experts on all the rules and regulations for every company.

Please acknowledge the above statements regarding your Vision Plan / Medical Insurance / Vision Discount Plan and its limitations. You have the opportunity to ask questions, and understand that you are responsible for any professional services you may receive today.

Payment is expected at the time services are rendered.

Signed: _____ **Date:** _____

Insurance Policy

Your insurance coverage is a contract between you and your insurance company. It is up to you to know your policy. Even with a referral your insurance company may not pay and your services not be covered. You will be financially responsible for services rendered if your insurance company denies payment to us. If you have any questions, please call your insurance company directly.

It is your responsibility to obtain any and all referrals. Referrals cannot be backdated, as this is insurance fraud. If you do not have a referral, and one is required by your insurance policy, you are expected to pay for your visit at the time of service. We will supply you with a receipt so that you may apply for reimbursement from your insurance company.

We accept assignment from many insurance companies. The companies pay a percentage of the approved amount. It is the patient's (guarantor's) obligation and the law that you pay any remaining deductible and balance between the approved amount and the amount paid by the insurance company. If for any reason your insurance company does not pay for your visit, it then **BECOMES YOUR RESPONSIBILITY**. It is your responsibility to know the contract between you and your insurance company. Please provide us with all the necessary information needed to process your claim.

Primary Vision Insurance
Company: VSP / VBA / Eyemed / Davis _____
Insured's Name _____ Patient's Relationship to Insured : Self / Spouse / Child _____
Policy # _____ Insured's DOB: _____ SS # _____

Secondary Vision Insurance
Company: VSP / VBA / Eyemed / Davis _____
Insured's Name _____ Patient's Relationship to Insured : Self / Spouse / Child _____
Policy # _____ Insured's DOB: _____ SS # _____

Primary Medical Insurance
Company: Horizon / Medicare / Aetna _____
Plan Name _____ Policy # _____ Group # _____
Patient's Relationship to Insured Self / Spouse / Child / Other _____
Insured's Name _____ Insured's DOB: _____ SS# _____

Secondary Medical Insurance
Company : _____
Plan Name _____ Policy # _____ Group # _____
Patient's Relationship to Insured Self / Spouse / Child / Other _____
Insured's Name _____ Insured's DOB: _____ SS# _____

We will directly bill your insurance company as a courtesy to you only when the below criteria have been met:

1. Benefits must be verified by our office **prior** to any service.
2. Patient liability must be paid at time services are rendered.

For those companies that we do not have a contract with, payment for services must be **paid for in full** at time of service.

I have read, understand and will comply with the above mentioned Insurance Policies.

Signature _____ Date _____

**insurance companies state that we must have on file your signature for release of records and authorizing payments.
Please sign and date in the boxes below.**

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process a claim for services rendered. I also request payment of benefits to either myself or the party who accept assignment of benefits

Signature _____ Date _____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical/optical benefits to Elite Eyecare Associates/Dr. J. Scot Ellis, O.D. for Optometric and Optical Services

Signature _____ Date _____

Established Patient History

Patient First Name: _____ Last Name _____ Date: _____

Reason for TODAY'S Visit	
Routine Eye Exam Yes/No Eye Irritation Yes/No	Do you work on a computer? Yes / No
Need/Want Glasses Yes/No Sunglasses Yes/No	How many hours per day? _____
Need/Want Contacts Yes/No Have you worn them previously Yes / No	Do you have sunglasses? Yes / No
Lasik-Laser Vision Correction Evaluation Yes/No Need more info? Yes/No	Sports/Hobbies _____
Are there any issues or concerns that you would like to address with the Doctor today:	Do you have specific visual needs that need to be addressed? Yes / No
_____	Explain _____
_____	_____
_____	_____

PHYSICAL HISTORY

Date of Last **PHYSICAL EXAM** _____ Doctor _____ Town _____

Specialty Physician _____ Specialty _____ Town _____

Specialty Physician _____ Specialty _____ Town _____

We like to communicate exam results to your Primary and Specialty physicians.

Who should we send a report to? _____

Are you diabetic/pre-diabetic? Yes / No Last A1c _____ Date of last Blood work? _____

Last Home testing _____ What was the reading _____

Do you have High Blood Pressure? Yes / No Are you a smoker yes / No

Have you been diagnosed, or are you being treated for any new medical condition that you did not have during your last visit? Yes / NO

If so, what condition (s)? _____

Do you have any allergies? Yes / No If so, to what? _____

Women: Are you pregnant? Yes / No How many weeks? _____ Are you Nursing Yes / No

Do you experience dry, irritated or itchy eyes? Yes / No Are you using artificial tear drops Yes / No How many times a day _____

Many systemic medications affect your vision and the health of your eyes. Please list your medications below or allow us to copy your list.

PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. A \$20 (TWENTY DOLLAR) BILLING CHARGE WILL BE APPLIED TO ALL OUTSTANDING BALANCES, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. THE RETURNED CHECK FEE IS \$30 (THIRTY DOLLARS). PATIENTS ARE RESPONSIBLE FOR ALL COSTS ASSOCIATED WITH COLLECTIONS OF LEGAL ACTIONS. THERE WILL BE A \$30 "NO-SHOW" CHARGE FOR NOT KEEPING APPOINTMENTS UNLESS WE HAVE BEEN NOTIFIED 24 HOURS IN ADVANCE.

This information is confidential and was given by: _____ **Date** _____