Welcome to Norman Vision Clinic

Appointment Time:_____Arrival Time:_____Today's Date____/_____/_____ Date of Birth:____/____/_____

_____ _____ _____ _____

Legal Last Name First M Preferred / Nickname

Email Address:_____ Cell Phone:_____

Alternate Phone:_____ Social Security # _____/_____/_____ Marital Status M S D W

Mailing Address:_____

STREET/PO BOX CITY STATE ZIP

If Patient is a Minor, Parent/ Legal Guardian:_____ Relationship:_____

Employer:_____ Occupation:_____ School_____

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Responsible Billpayer (if other than person listed above):_____

Date of Birth____/____/____ Billpayer's SS#_____ Relationship to Patient_____

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Primary **Vision** Insurance:_____ (please provide card)

Primary **Medical** Insurance:_____ (please provide card)

Secondary **Medical** Insurance:_____ (please provide card)

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Who should we contact in case of an emergency?

Name:_____ Relationship:_____PHONE #:_____

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May we send reminders via text? Yes No (circle one)

May we contact you via text or email regarding orders for contact lenses you may have placed or are due to place so that you have more control over your own orders and can track their delivery? Our system is called MARLO, Yes No (circle one)

How do you prefer that we contact you? Cell Phone Email Alternate Phone (Circle one)

Acknowledgement of receipt of HIPAA Notice of Privacy Policy

"I acknowledge that I received and/or have been offered a copy of the "Notice of Privacy Policy" for Norman Vision Clinic

X_____ _____/_____/____

Patient/ Parent/ Legal Guardian Signature Date

We will require a copy of ALL of your Insurance cards every time you come in for an appointment to determine if we are providers! Your Insurance cards are much like your credit card as a form of payment and if you do not present them then you will be considered SELF PAY!

We accept Visa, Mastercard, Discover, American Express, Care Credit, Cash and Checks

Please Turn This Page Over and Sign At All the X Spots!

Notifications

- *Insurance cards must be presented at time of service or patient will be considered self-pay.*
- *All co-payments and non-covered services are due at time of service.*
- *Verification of benefits is not a guarantee of payment.*
- *Drs. of Norman Vision Clinic will not become involved with disputes between the patient and their insurance company.*
- *It is the patient's responsibility to confirm that the Drs and Norman Vision Clinic are network providers for your insurance. It is also your responsibility to seek out authorizations and referrals from your PCP if needed.*
- *Any patient under the age of 18 must be accompanied by a parent or guardian. By signing below I understand that I am responsible for any incurred charges for the minor patient named. The parent who brings the child in for care is ultimately responsible for their bill as we will not get involved in child custody disputes.*
- *I understand that the standard eye exam does not cover the additional cost of a contact lens evaluation.*
  Please ask your technician or someone at the front desk what the cost of a contact lens fit/evaluation would be as insurance typically does not cover this service and it can range from $30 to $200.
- *MEDICARE- Our doctors are participating providers with Medicare. Medicare does not cover routine vision services. The Refraction which is the test used to determine your prescription for glasses and or contacts are not covered and usually costs $35. This cost will be your responsibility. You will also be responsible for the Medicare annual deductible and the 20% coinsurance unless you have a supplement that covers those amounts.*

Payment Policy - Please Read Carefully

Fees not covered by your insurance, co-pays and overages are due when services are rendered. When materials are necessary, glasses or contact lenses we require payment in full prior to order. If your insurance denies a service the balance will be considered your responsibility and due within 30 days. A debt is considered delinquent if not settled within 60 days and may be turned to our collection agency. If your account is turned to our collection agency a delinquent account fee of 40% of the balance due will be added to the balance to cover the cost of collections. Our returned check fee is $25 if settled within 10 days with our office. However, if the returned check is not settled within 10 days it will be sent to the District Attorney's Office Bad Check Division for legal collection and a warrant may be issued. Once this is done any settlement of the matter has to be handled with the District Attorney's Office.

"I have read and agree to the above Payment Policy and Terms of Service."

X_____ ___/____/____

Patient/Parent/Legal Guardian Signature Date

INSURANCE SIGNATURE ON FILE – LONG TERM AUTHORIZATION FOR US TO FILE YOUR INSURANCE

I request payment of authorized Medicare and / or Medicaid and /or Medical and / or Vision Benefits be made on my behalf to the Drs. Of Norman Vision Clinic, PLLC for any services furnished to me by these Optometric or Ophthalmologic Physicians. I authorize any holder of Medicare, Major Medical or Vision Information about me be released to the Health Care Financing Administration and it's agents, or my private insurer (mayor medical or vision) any information needed to determine these benefits are payable for related services.

X_____ ____/____/_____

Patient /Bill Payer/Parent/Legal Guardian Signature Date