Middlebury Eye Associates, Inc.

Welcome to our office

Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you place in us. Please take a moment to complete the following information. If you have any questions, don't hesitate to ask.

☐ **Mr.** ☐ **Miss** ☐ **Mrs.** ☐ **Ms.** ☐ **Dr.** **Sex originally listed on birth certificate:** ☐ **Female** ☐ **Male**

Preferred Pronoun: ☐ **He/Him** ☐ **She/Her** ☐ **Them/They** ☐ **Other ______________________**

First Name:________________________________ **Middle initial:________** **Last Name:_________________________**

Mailing Address:___________________________________ City:___________________________ State:________ Zip:__________

Date of Birth:________________ **Preferred Phone:________________________** **Second Phone:___________________________**

Email: ____ **Patient Employer:___________________________________**

Parent/Guardian if patient is a minor:______________________________

Emergency Contact:______________________________________ **Emergency Contact Phone:_______________________________**

Preferred Method of Communication (please choose at least one): ☐ **Text** ☐ **Email** ☐ **Phone**

Below is our insurance and payment policy. Please take a moment to read and understand it. If you have any questions, please don't hesitate to ask any member of our staff.

I understand that the exam fees are based on my symptoms, procedures, and level of complexity of my problem. This can only be determined by the doctor during the visit.

Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. We participate in many, but not all, insurance plans. If you are not insured by a plan, full payment is expected at each visit. If you are insured by a plan, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance. If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to and help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud.

With insurance we participate with, we will submit your claims and assist you to help get your claims processed. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to this contract. Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by insurers. You must pay for these services in full at the time of your visit.

We require half down on all eyeglass orders before ordering, and payment in full a0t time of dispense. Contact lenses must be paid in full at time of dispense. If your account is over 90 days past due, your account will be sent to our collection agency. Partial payments will not be accepted unless otherwise negotiated. For any returned check we will attempt to notify you, and will add a $25 returned check fee to your bill.

We do not charge for missed appointments, but we ask that you cancel within a reasonable amount of time. Please help us to serve all our patients better by keeping your regularly scheduled appointment.

By signing below, I acknowledge and understand that Middlebury Eye Associates, Inc. will assist me in billing my insurance. I understand and agree that regardless of my insurance, I am, in the end, responsible for the balance of my account for any professional services or materials rendered.

Signature:____ **Date:**______________________

VSP Participants: If your insurance coverage includes a Vision Service Plan (VSP), understand that the doctor will determine if a medical diagnosis is necessary. If there is any medical diagnosis, Middlebury Eye Associates, Inc. will coordinate billing between your medical insurance first and your VSP second. You are responsible for any remaining balance your insurance doesn't cover. Not all VSP plans allow coordination of benefits.

Signature:____ **Date:**______________________

Our Responsibilities: We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. Middlebury Eye Associates, Inc. will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.middleburyeye.com

Changes to the Terms of this Notice: We reserve the right to change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Printed Name: __________________________________

Signature:_____________________________________

Date:_______________________________________

Do we have permission to speak with someone other than yourself?

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

Name:____ **Relationship to Patient:**____________________

Name:____ **Relationship to Patient:**____________________