MIDDLETOWN EYE CARE

Frank R. Burns, M.D.
David Strickland, M.D.

Patient Name____

SSN____________________ **DOB**__________________ ○ **Male** ○ **Female**

Address__________________________ **City**____________________ **State** _____ **Zip**_________

Home phone______________________ **Cell phone**________________________

Consent to leave a Voicemail: YES / NO **Consent to receive a text message**: YES / NO

Email address____

Preference for appointment confirmation for future use - Phone call______Text _______Email _______

Please check appropriate box: ○ Minor ○ Single ○ Married ○ Widowed ○ Other

Race ____________ **Ethnicity:** ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Unknown

Employer ________________________________ **Work phone** ______________________

Occupation _______________________________ **Pharmacy**_________________________

Person to contact in case of an emergency ______________________________________

Emergency Contact Phone # ______________________ **Relationship to you** ________________

Where did you first hear of our practice ______________________________________

Family Physician or Internist: ____

RESPONSIBLE PARTY

Name of Responsible Party _______________________________ **SSN** __________________

Relationship to patient ______________**Address if different from patient** _____________________

City __________________**State**_______**Zip** ________**Phone number** _________________________

DILATION RELEASE

I, the undersigned, have been advised by Middletown Eye Care that my eyes may be dilated for each exam. I further understand that I have been advised to provide myself with transportation and it is not recommended that I drive after being dilated. I accept all responsibility for the consequences of not following theses recommended guidelines.

Patient's Signature: _____________________________________ **Date:** ____________________

PLEASE ATTACH A LIST OF MEDICATIONS OR WRITE ON THE BACK OF THIS PAPER

13324 Shelbyville Rd. - Middletown, KY 40223
Phone: (502) 245-0305
Fax: (502) 254-1425

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FINANCIAL POLICY

Insurance Coverage

Your health insurance policy is a contract between you and your health insurance company. It is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals and/or pre-authorizations. You should be knowledgeable about any deductibles, copayments and/or coinsurance that are due. **Middletown Eye Care *does NOT participate with ANY vision insurance plans.*** Our office belongs to most major insurance plans. Before your appointment, please be sure Dr. Burns and/or Dr. Strickland are in-network, and the services are covered under your plan. If you are uncertain about your current health insurance policy benefits you should contact your plan to learn the details of your benefits, out-of-pocket expenses, and coverage limits.

Insurance Referrals

You are responsible for obtaining and providing us with any referrals required by your insurance. Without this information, your insurance company may not pay for services, and the balance will be your responsibility.

Payments or Co-payments.

All co-payments are due at the time of service. Your secondary insurance may or may not cover your copayment and/or co-insurance. If your secondary covers your co-payment, we will issue you a refund. If you are unable to make these payments, your appointment may be rescheduled. There will be a $25 fee assessed on returned checks.

Deductibles and Co-Insurance

As a courtesy we will bill your insurance according to all federal, state, and other contractual requirements in cases where we have an agreement, or we are a participating provider. Once they have paid, we will send you a detailed bill for the remaining amount owed to Middletown Eye Physicians PLC / Middletown Eye Care

Non-Covered Services

If your insurance plan determines a service to be "not covered", you may be responsible for the complete charge. You agree to pay any portion of the charges not covered by insurance. The balance is due in full within 30 days of receipt of the statement.

Past Due Balances

Patients with past due accounts will be sent two additional statements requesting payment. If there is no resolution, your account will be sent to a collection agency, and you may be discharged from the practice for lack of payment.

Refraction Fee

Refraction is the process used to determine your best-corrected vision potential. While not covered by most insurance companies (including Medicare) a refraction may be needed to help determine your best vision potential, or if you request a new glasses prescription. ***Our refraction fee is $50, payable at the time of the service***. This charge is in addition to office visit charges, co-payments and/or deductibles. The fee covers the time and effort needed to refract, review the refraction, and make a clinical judgment on the refractive state of the eye(s).

Self-Pay

Self-pay accounts are for patients without insurance coverage or patients covered by insurance plans with which Middletown Eye Care is not contracted. Self-pay patients who are new or returning are required to pay the balance at the time of service.

Missed/Canceled Appointments

Please contact us as soon as you know you will not be able to keep your appointment. To avoid a "missed appointment fee" of $50, we request you inform us within 24 hours of the day of your appointment. A frequent pattern of appointment cancellations and/or visit "no shows" may result in a patient's discharge from our care, as such cancellation makes it challenging for our office to provide appropriate continuity of care and inhibits care we can provide to other patients.

Completion of Forms and Release of Medical Records

Completion of disability forms, FMLA forms, and other supplemental insurance forms all require doctor and staff time to complete, therefore a $25.00 fee for each form will be charged and must be pre-paid. There will be a 14-day turnaround time for completion, so please plan accordingly. Payment is required in advance.

Assignment of Benefits, Responsibility to Patient, Termination of Services

I hereby assign all medical and surgical benefits to which I am entitled. I hereby authorize and direct my insurance to issue payment directly to Middletown Eye Physicians / Middletown Eye Care for medical services for myself and/or my dependents. I have read and understand the financial policy and I agree to be bound by its terms. I understand and agree that such terms may be amended by the practice from time to time.

____________________________ Print Name of Patient

____________________________ Signature of Patient (or responsible party)

____________________________ Date of Birth

____________________________ Date of Signature

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RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that as part of my health care, Middletown Eye Care, originate and maintain health records. These health records describe my health history, symptoms, examination and test result s, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and medical treatment information to my bill
- A means by which a third -party payer{i.e. insurance company) can verify that services billed were provided
- In order to assess the care and the outcome in your case and others like it, in order to assure the highest quality of care for our patients

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

I understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my PHI is available to me. I understand that this organization has the right to change it's notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the **Notice of Privacy Practices.**

- **Please list below the name(s) and relationship of any persons that we may discuss your medical condition(s) with:**

____

____

Patient Name: ________________________ **DOB**: ______________

Patient Signature: ________________________ **Date:**______________

Relationship to patient (if not self): ________________________

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