Old Saratoga Eyecare Patient Agreement

Our office is committed to providing you with the best possible care. If you have medical insurance, we will help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and your understanding of our payment policy. We participate with select medical insurance plans. We will gladly bill your insurance company as a courtesy to you. Filing the claim on your behalf does not guarantee payment. If an open balance is not collected and goes into default, you will be responsible for all collection agency fees and contingent legal costs.

REFERRAL WAIVER: Understand that if you request and receive treatment from Old Saratoga Eyecare *without providing the required referral form and/or insurance identification card(s)*, that you shall be personally responsible for any charges related to this and any future office visits or for services provided to you and/or your dependents.

RELEASE OF INFORMATION: You hereby authorize the release of any information about you and/or your dependent to other healthcare providers participating in your/their care and treatment, as well as to insurance/reimbursing payers in order to process and facilitate payment of your/their treatment.

MEDICARE LIFETIME SIGNATURE ON FILE AND AUTHORIZATION: (If applicable): You certify that the information given by you to apply for payment under Title XVIII of the Social Security Act is correct. You authorize any holder of medical or other information about you to be released to the Social Security Administration and/or its carriers any information required to process your medical claims. You request that payment of authorized benefits be made on your behalf to Old Saratoga Eyecare for services provided to you during the period you are under the care of this establishment.

MEDIGAP OR SUPPLEMENTAL INSURANCE (if applicable)**:** You request that payment of authorized Medigap or supplemental benefits be made on your behalf to Old Saratoga Eyecare for any services furnished to you by this establishment. You also authorize any holder of medical information about you to release to the Medigap or supplemental insurer any information required to process and determine these benefits payable for related services.

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CONSENT/REQUEST FOR TREATMENT: I hereby voluntarily request and consent to treatment of myself or noted dependent by Old Saratoga Eyecare.

_____ _____

Signature of Patient/Parent/Legal Guardian/Other **Date**

_____

Relationship to Patient

Old Saratoga Eyecare Registration Form

(Please Print)

Date_____Circle one: Mr./Mrs./Miss/Ms. Circle one: Single/Married/Widowed/Divorced

First Name_____MI_____Last Name_____

Address_____Apt#_____

City_____State_____Zip_____

Home Phone#_____Cell Phone #_____

Email Address_____

Date of Birth_____

Place of Employment / School_____

Work Phone #_____Ext._____

Emergency Contact_____Phone #_____

Who may we thank for referring you to our office? _____

Primary Care Physician (PCP): _____

Primary Medical Insurance:_____
(Please fill out the following if card holder of insurance is different from above)

Policy Holder Name_____Last 4 digits of SS#_____
Date of Birth_____ID#_____Group#_____

Secondary Medical Insurance:_____
(Please fill out the following if card holder of insurance is different than above)

Policy Holder Name_____Last 4 digits of SS#_____
Date of Birth_____ID#_____Group #_____

ASSIGNMENT OF BENEFITS: Insurance coverage is a contract between you and the insurance company you participate with. We can "estimate" what your insurance company may pay. However, it is your insurance company that makes the final determination of your eligibility and coverage. By signing this form, you authorize and direct payment of your medical benefits to Old Saratoga Eyecare for any services and/or treatments furnished to you by this establishment. Understand that you are financially responsible for any non-covered services, treatments, and/or balances. Co-payment is expected at time of service.

***** SEE OTHER SIDE *****