GUNDERSON EYECARE

Patient Information

Date: _____/_____/_____

Full Name: _____ **Date of Birth:** _____/_____/_____

Please add your middle initial to your full legal name.

Preferred Name: _____

Street Address: _____Apt #_____

City:_____ State: _____ Zip Code: _____

Social Security/Government ID: _____

Who is your employer? _____ Job Title: _____

Marital Status: Single Married Divorced Widowed Other

Family Physician: _____

Who can we thank for referring you? _____

Preferred Language: English Spanish Korean Chinese Tagalog Vietnamese

Other: _____

Preferred Gender: Male Female Other: _____

Gender on Insurance: Male Female

Contact Information

Write 1, 2, or 3 on the line for the order in which you prefer to be contacted.

Text: _____ **Call (Cell):** _____ **Call (Home):** _____ **Call (Work):** _____ **E-mail:** _____

Cell: _____ Work: _____ Home: _____

E-mail: _____

Insurance Policy Holder Information

Are you the primary insurance holder? Yes No

(If "No", please fill out the following information. If "Yes", please sign and date.)

Policy Holder's Full Name: _____Date of Birth: ____/_____/____

Policy Holder's Employer: _____
First *M.I.*

Policy Holder's Social Security/Government ID: _____

I give Gunderson Eyecare permission to bill my insurance company and to release any pertinent information that is needed to process my claim.

Signature: _____ Date: _____/_____/_____

HIPAA Notice of Privacy Practice and Medical Release

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You also agree to receive your glasses and contact lens prescription via email (Paper copies are available upon request). You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form. You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction. **A Copy of the HIPAA Notice of Privacy Practices will be provided to you upon request.**

I also give permission to share information pertaining to my care to the following person(s):

1: Name: _____ Relationship: _____

2: Name: _____ Relationship: _____

3: Name: _____ Relationship: _____

By signing this document, you signify that you have read and agree to the statements listed above. You can revoke this agreement in writing at any time prior to treatment. Your signature will remain on file indefinitely, unless revoked by you or your representative.

Patient Signature or Parent/Guardian Signature: _____

Printed Patient's Full Name: _____ Date: _____/_____/_____

Witness's initials: _____

GUNDERSON EYECARE

Financial Policy

Terms: This is an agreement between Gunderson Eyecare, P.C., as creditor, and the Patient/and Responsible Party named on this form, as debtor. In this agreement the words "you, your, and yours" mean the Patient/and Responsible Party. The word "account" means the account that has been established in patients or responsible party's name to which charges are made and payments credited. The words "we, us, and our" refer to Gunderson Eyecare, P.C. By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payment options if you have no insurance:
1. You may choose to pay by cash, check, debit card, Visa, MasterCard, or Discover Card on the day that treatment is rendered.
2. On products ordered especially for you such as glasses and contact lenses, you may choose to pay 50% at time of order and the remainder of the bill at the time of delivery.

Payment options if you have insurance:
1. You may choose to pay your deductible and any out-of-pocket portions at the time services are rendered by cash, check, or credit card and request that we submit a claim to your insurance company.
2. You may choose to pay all of your treatment by cash, check, or credit card and request your insurance carrier to send their payment directly to you.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company and you will be responsible for the additional amount.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are not party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company and you will be responsible for the additional amount.

The Financial Policy continues on the back side of this page.

Patient's Name: _____

Responsible Party
(If not the patient):_____

Signature: _____ Date:_____

Co-Signature_____ Date:_____

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within (30) thirty days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one and one half percent (1.5%) per month or an **ANNUAL PERCENTAGE RATE** of eighteen (18%) percent. The finance charge on your account is computed by applying the periodic rate (1.5%) to the "overdue balance" of your

account. The “overdue balance” of your account is calculated by taking the balance owed thirty (30) days ago and then subtracting any payments or credits applied to the account during that time.

Required Payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Returned checks: There is a fee (currently $25) for any checks returned by the bank.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer’s fees which we incur plus all court costs. In case of a lawsuit, you agree the venue shall be in Dubois County, Indiana.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if you’re past due status is reported to a credit agency, the fact that you received treatment at our office may become a matter of public record. You also understand that inquiry may be made by the Responsible Party and statements may be issued to the Responsible Party, and you hereby consent to disclosure to the Responsible Party if the Responsible Party is not also the Patient.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account if said party was responsible at the time the charges were incurred. After a divorce or separation, the parent authorizing treatment for a child will be the party responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent’s responsibility to collect from the other parent.

Transferring Records: You will need to request record transfers in writing. A reasonable copying fee will be charged for some record transfers. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Worker’s Compensation: We require written approval/authorization by your employer and/or worker’s compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient’s responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until cancelled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Phone Consultation and Tele-health charges will apply for voice or digital correspondence when resulting in prescriptions being sent to the pharmacy on the patient’s behalf or extensive discussion regarding eye conditions.