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# DEMOGRAPHIC & PAYMENT INFORMATION

**Patient Name:** _____ **Date of Birth:** _____ **Sex: M / F**

**Address:** _____

**Cell Phone:** _____ **Home Phone:** _____

**Email:** _____ **Employer:** _____

**Social Security #:** _____ **Marital Status:** Single / Married / Divorced / Widowed

## RESPONSIBLE PARTY/GUARANTOR:

**Same as patient? YES** ☐ (write "SAME") **NO** ☐ (Complete this section for responsible party)

**Responsible Party Name:** _____ **Date of Birth:** _____

**Responsible Party SS#:** _____ **Employer:** _____

**Address:** _____

**Cell Phone:** _____ **Home Phone:** _____

**Relationship to Patient:** Self / Spouse / Child / Other _____

## PRIMARY INSURANCE:

**Name of Insured:** _____

**Relationship to Insured:** Self / Spouse / Child / Other _____

**Insured SS#:** _____ **Birth Date:** _____

**Employer:** _____

**Insurance Name:** _____

**ID#:** _____ **Group#:** _____

## SECONDARY INSURANCE:

**Name of Insured:** _____

**Relationship to Insured:** Self / Spouse / Child / Other _____

**Insured SS#:** _____ **Birth Date:** _____

**Employer:** _____

**Insurance Name:** _____

**ID#:** _____ **Group#:** _____

## WORKER'S COMPENSATION INFORMATION:

Is this a Worker's Comp Claim: YES or NO If YES, Date of Accident: _____ Employer Notified: YES or NO

Employer Name/Phone: _____ WC Claim #: _____

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# SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

**RELEASE OF INFORMATION:** I understand and authorize Independent Vision Group, Ltd (IVG) to disclose Personal Health Information (PHI) necessary to provide me with appropriate care to my optometrist/ophthalmologist and surgical facility. I also understand and authorize IVG to disclose PHI necessary for reimbursement of services rendered under Treatment, Payment and Operations to my insurance(s), Worker's Compensation and Health Care Financing Administration, and any additional information about me needed to determine these benefits or the benefits payable of my bill. In addition, I grant the following person(s) permission to speak with Independent Vision Group, LTD regarding my medical records, treatment and billing:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

**INSURANCE AGREEMENT:** Any benefit of any type, under any policy of insurance, insuring the patient or any other party liable to the patient, is hereby assigned to Independent Vision Group, Ltd for any services furnished to me by Thomas Harvey, MD. If co-payments and/or deductibles are designated by my insurance company or my health plan, I agree to pay them to Independent Vision Group, LTD. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Independent Vision Group, LTD, if I belong to a plan that is not on their list of contracts.

**NON-COVERED SERVICES:** I understand that Independent Vision Group's contracts with health care service plans (e.g. HMOs, PPOs) relate only to the items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to: refractions, corneal topography, and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Independent Vision Group, Ltd to obtain any and all necessary health care service plan authorizations.

**FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Independent Vision Group, Ltd, I will pay the co-pay at or before the time service is rendered as well as any account balance, including deductibles and co-insurance obligations. If an account is sent to a collections agency, I agree to pay collection expenses and reasonable attorney fees as established by the court. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice.

**REFRACTIONS:** In most cases you will be responsible for the cost of "refractions." This service is the determination of the need for glasses or change in your current glasses prescription. This is considered a "non-covered" service by Medicare, or routine care. Most secondary carriers do not cover this service since it is "non-covered" by Medicare. Therefore, payment for any "refraction" is due from you upon completion of your eye examination for the "refraction." Independent Vision Group, Ltd will still submit this charge to your primary and secondary insurance as part of the claim for your visit.

**COMMUNICATION PRIVACY NOTICE:** By supplying my home phone number, cell phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving of multiple messages per day from my healthcare provider, when necessary. I consent to allowing the above detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

**HIPAA NOTICE:** Independent Vision Group Ltd's Notice of Privacy Practice is available at www.inde-vision.com. I acknowledge that a printed version is also available at my request.

**I HAVE READ, UNDERSTAND AND AGREE WITH THE RELEASE OF INFORMATION, INSURANCE AGREEMENT, NON-COVERED SERVICES, FINANCIAL AGREEMENT AND REFRACTIONS POLICY LISTED ON THE FRONT AND BACK OF THIS DOCUMENT.**

_____ _____

**PATIENT BENEFICIARY / RESPONSIBLE PARTY / GUARDIAN SIGNATURE** **DATE**