EYE SURGEONS *of* INDIANA

INFORMATION RECORD

PERSONAL INFORMATION

NAME _____
LAST FIRST MIDDLE INITIAL

ADDRESS _____
STREET OR POST OFFICE BOX CITY STATE ZIP CODE

TELEPHONE _____ _____ _____
HOME WORK - IF APPLICABLE MOBILE

SOCIAL SECURITY # ___ ___ ___ - ___ ___ - ___ ___ ___ ___ **BIRTHDATE** ___ ___ / ___ ___ / ___ ___ ___ ___

GENDER ☐ Male ☐ Female **MARITAL STATUS** ☐ Single ☐ Married ☐ Widowed

EMPLOYER _____ _____ ☐ Retired
COMPANY OCCUPATION

_____ _____ ☐ Retired
SPOUSE'S COMPANY OCCUPATION

EYE DOCTOR _____ _____ _____
NAME CITY PHONE

MEDICAL DOCTOR _____ _____ _____
NAME CITY PHONE

EMERGENCY CONTACT _____ _____
NAME (SOMEONE **NOT** IN YOUR HOUSEHOLD) PHONE

E-MAIL _____

HOW WERE YOU REFERRED TO US?
☐ Family Doctor ☐ Insurance Company
☐ Family Optometrist ☐ Phone Book
☐ Friend/Relative ☐ Internet Listing
_____
NAME

INSURANCE INFORMATION

PRIMARY INSURANCE _____ _____ _____
INSURANCE COMPANY NAME ID NUMBER GROUP NUMBER
☐ Prior Authorization Required

SECONDARY INSURANCE ☐ Yes ☐ No

(IF YES) _____ _____ _____
INSURANCE COMPANY NAME ID NUMBER GROUP NUMBER
☐ Prior Authorization Required

WORKER'S COMP CLAIM? ☐ Yes ☐ No _____ _____
EMPLOYER ADDRESS

(IF YES) _____ _____ _____
CONTACT NAME CONTACT NUMBER PHONE

_____
POLICY HOLDER'S NAME

PERSON RESPONSIBLE FOR PAYMENT _____ _____ ___ ___ ___ - ___ ___ - ___ ___ ___ ___
NAME RELATIONSHIP SOCIAL SECURITY #

_____ _____ ___ ___ / ___ ___ / ___ ___ ___ ___
HOME PHONE WORK PHONE BIRTHDATE

F007-1203

Please remember to fill out the other side

2019

IMPORTANT

Please complete every section that is applicable to you

MEDICARE

I hereby authorize by my signature that Eye Surgeons of Indiana and the Surgical Care Center (as applicable) submit a claim on my behalf for payment under the Medicare program. I also authorize by my signature that payment of Medicare program benefits be assigned and made payable on my behalf to Eye Surgeons of Indiana and / or the Surgical Care Center for all services and supplies provided to me by my doctor and the Surgical Care Center. I further authorize the release of my medical information to Medicare should Medicare require the information in order to adjudicate the amount due to Eye Surgeons of Indiana and / or the Surgical Care Center.

PATIENT NAME _____ MEDICARE # _____

SIGNATURE _____ DATE _____

OTHER INSURANCE

I hereby authorize by my signature that Eye Surgeons of Indiana and the Surgical Care Center (as applicable) submit a claim on my behalf for payment of benefits available through my insurance coverage with _____. I also hereby authorize by my signature that all payments due to me from my insurance carrier are herewith assigned and made payable on my behalf to Eye Surgeons of Indiana and / or the Surgical Care Center for all services and supplies provided to me by my doctor and the Surgical Care Center. I further authorize the release of my medical information to my insurance carrier should the information be required in order to adjudicate the claim submitted by Eye Surgeons of Indiana and / or Surgical Care Center.

PATIENT NAME _____ MEDICARE # _____

SIGNATURE _____ DATE _____

TO BE FILLED OUT BY ALL PATIENTS

I understand that Eye Surgeons of Indiana and / or the Surgical Care Center will submit a claim on my behalf to my insurance carrier. I agree to pay upon receipt of a bill, the full amount due and payable for the services and supplies I have received, less applicable insurance payments, unless prior payment arrangements have been made with the C ollection Department. I understand that I will be responsible for all costs associated with the collection of my balance due, including collection fees and attorney's fees, should the balance become delinquent. I fully understand that I am financially responsible for the payment of the full amount of the services and supplies that I receive and I agree to pay the full amount or balance due thereof should my insurance carrier fail to make any payment, or make payment for less than the total of the charges. Insurance payments in question are a matter to be resolved between the insurance policyholder and his or her insurance carrier within 30 days of receipt of payment. I agree to pay the account balance in full, which is outstanding more than 30 days beyond the date of receipt of the insurance payment(s).

PATIENT NAME _____ DATE _____

SIGNATURE _____ DATE _____

WITNESS _____ DATE _____

EYE SURGEONS *of* INDIANA FINANCIAL POLICY

The doctors and staff at Eye Surgeons of Indiana want you to have a pleasant and professional experience when you visit us. Our doctors are Board Certified and have spent years in learning their profession. We utilize state-of-the-art equipment to care for your eyes. Our staff also put many training hours into learning how to serve you in a safe and appealing environment. In order for us to help every patient have an efficient and rewarding appointment we are providing this information to explain what you should expect from us and what we expect from you regarding the service you are receiving.

CLAIM FILING

As a courtesy, Eye Surgeons of Indiana will bill your primary and secondary insurance carriers. However, the payment for the services you receive is your responsibility and we will not "hold" a claim or balance due pending an insurance dispute. We will ask for your insurance card at each visit in order to ensure we have the proper information to bill your insurance company. We expect your insurance carrier to pay us within sixty days from the date of your visit. If your insurance does not pay us within the sixty day period we will bill you for the services you received, and it will be your responsibility to contact your insurance company regarding payment. It is also your responsibility to understand your individual insurance plan. Should your insurance plan require a referral from your family doctor you must obtain it before seeking our services. If you do not obtain the proper referrals or authorizations, we will bill you directly and expect full payment from you. You will be responsible for all out-of-network fees and penalties unless these are discussed with our staff prior to your visit or surgery.

OFFICE VISITS

During your initial and follow-up office visits there may be additional charges for special tests or procedures that are necessary for your eyes' health. Examples of these tests include visual fields, ocular photography, and IOL Master Analysis.

PAYMENT POLICY

All co-pays and deductibles are due at the time of service. If you do not have insurance or do not have your insurance card we require full payment at the time you receive care, or we may reschedule your appointment. If you are going to have surgery you will speak with one of our Surgical Schedulers, who will explain your surgery and the methods of payment for the surgery. If you do not have insurance, or if the care you are to receive is not covered by your insurance provider, we require payment prior to the surgery. We accept cash, checks, money orders, credit cards, and Care Credit. There is a $35 service charge for all returned checks. Other payment plans may be available to you under extreme circumstances–please explain your concerns to the Surgical Scheduler at the time you speak with them.

It is very likely that your eyes will be refracted at the time of your office visit. This procedure is done in the interest of providing you the best possible care while you are with us. Medicare and most insurance carriers do not pay for this service, so you will be required to pay for it at the time of your visit. All co-pay fees will be collected at the time of service.

No-shows and late cancellations represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for no-shows or late-cancelled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice. There is a potential charge of $35 for all no-show appointments and cancellations less than 24 hours prior to your scheduled visit.

MEDICAL RECORDS AND FORMS

We will charge a labor fee of $20 per record plus .50¢ a page for all pages beyond 10 that are copied. If the labor charge is imposed the first 10 pages will not be charged. If the records are acquired within 48 hours an additional $10 may be charged for the rush retrieval. All fees are payable prior to release of records. Government regulation limits, but allows for, these fees and requires us to obtain a Medical Records Release form prior to release.

If you require disability forms to be completed a fee of $35 will be charged. All other forms such as FMLA, parking permits, physician-dictated return-to-work statements and any other record other than medical records will be completed for a fee of no less than $10. All fees are payable at the time of request. If forms or records cannot be completed any fees paid will be refunded.

OUR COLLECTION POLICY

It is our desire to keep your account within our practice. However, if your account becomes delinquent and you have made no attempt to pay your bill or contact us we will turn your account over to an attorney or outside collection agency. If your account is placed with an attorney or collection agency you agree to pay: (a) costs of collection in the amount of $25.00 if your account is forwarded to a collection agency for collection; (b) reasonable attorneys' fees that are incurred in the collection of your account whether or not legal proceedings are instituted; (c) court costs; and (d) interest at the unpaid balance of the account at the statutory rate from the date it is turned over to the collection agency until paid in full.

CONTACTING OUR INSURANCE DEPARTMENT

You may call the following Insurance Department staff members for assistance regarding the bills you receive from Eye Surgeons of Indiana:

Patient Accounts	317-570-7426 ext. 1259 or 1274
Medicare	317-570-7426 ext. 1207
Commercial Accounts	317-570-7426 ext. 1207

All payments for services provided by Eye Surgeons of Indiana should be made payable to *Eye Surgeons of Indiana* and mailed to our Indianapolis office: 9202 North Meridian Street/ Indianapolis, Indiana 46260

I have read and understand this Eye Surgeons of Indiana financial policy.

_____ _____

SIGNATURE OF INSURED or AUTHORIZED REPRESENTATIVE SIGNATURE OF STAFF MEMBER

_____ _____

PRINTED NAME DATE OF BIRTH

_____

TODAY'S DATE