EYE HEALTH
VISION CENTERS
a CLARIS VISION™ company

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PATIENT INFORMATION

Patient Name: Address:

City: State: Zip:

Date of Birth: Sex: Female Social Security:

Home Phone: Cell Phone: Work Phone:

Email Address:

Primary Care Physician: Phone:

Emergency Contact: Relationship: Phone:

If Patient is a minor, Responsible Party

INSURANCE INFORMATION

Primary Insurance

Member ID #: Group #:

Policy Holders Information: (if different than above)

Name: _____ Date of Birth:_____

Social Security: _____ Sex: ____ Relation:

- ☐ Spouse
- ☐ Parent
- ☐ Other

Secondary Insurance: (if applies): _____

Member ID #: _____ Group #: _____

Policy Holders Information: (if different than above)

Name: _____ Date of Birth: _____

Social Security:_____ Sex: _____ Relation:

- ☐ Spouse
- ☐ Parent
- ☐ Other

The above information is true to the best of my knowledge.I authorize my insurance benefits to be paid directly to my physician.I understand that I am financially responsible for any balance including deductibles, coinsurance, copayment, and/or non-covered services.I also authorize _____ or my insurance company to release any information required to process claims.

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CONSENT FOR TREATMENT

- I authorize a Claris Vision, LLC to perform all procedures, tests, treatments, and other services necessary for my diagnosis and care. If specialized procedures, tests, or treatments are required, I understand that I may be asked to sign an additional consent form. I agree to promptly inform a Claris Vision, LLC of any changes to my health or vision. I understand that the information I provide to Claris Vision, LLC will be used to inform the care provided to me, and that I must fully answer all questions to the best of my knowledge. Although the ophthalmologist, optometrist, or other health care professional will explain my diagnoses, proposed treatments, and potential risks, benefits, and alternatives, I acknowledge that it is my responsibility to ask questions if I do not understand the information presented to me.
- I understand that dilating drops may be used to dilate or enlarge my pupils to allow the ophthalmologist or optometrist to get a better view of the inside of my eyes. Dilating drops frequently blur vision and make bright lights bothersome for a length of time which varies from patient to patient. Because driving may be difficult or hazardous after a dilated exam, I understand that I should make arrangements to have someone else drive me home. I authorize Claris Vision, LLC to administer dilating drops at any time during the course of my care as necessary to monitor and/or diagnose my condition.

INSURANCE AUTHORIZATION; ACKNOWLEDGEMENT OF PAYMENT POLICIES

I authorize Claris Vision, LLC to submit bills for my/the patient's care to my insurance companies and to release any information about me/the patient needed to secure payment for such care. I authorize my insurance companies to pay to a Claris Vision, LLC all benefits payable for services rendered. I authorize the use of my signature below for all insurance submissions, and I agree that a Claris Vision, LLC is not required to obtain an additional signature from me in order to submit any future insurance claims. I agree that I am financially responsible for all charges for services rendered if not paid by my insurance.

I understand that many insurance companies require patients to secure a referral from a primary care physician before being seen by a specialist, and I agree that I am responsible for securing referrals when needed. If my insurance company rejects [Practice's] claim for services due to my failure to secure a referral, I understand that I will be personally responsible for all charges for those services.

I also agree to be bound by the following payment policies and any future revisions to such policies:

- If a Claris Vision, LLC is a participating provider with a particular insurance company, it will bill the insurance company directly. All co-payments, co-insurance, deductibles, and services not covered by insurance must be paid at the time of treatment unless prior arrangements have been made with Practice. (Some exceptions may apply for patients with Health Reimbursement Account/Health Savings Account plans.)
- Patients who do not have the ability to pay amounts due at the time of treatment should meet with [Practice's] financial advisor prior to treatment.
- For certain types of insurance, a Claris Vision, LLC may accept assignment of benefits. In the event that a Claris Vision, LLC does not accept such assignment, payment must be made at the time of treatment.
- Not all services provided are considered necessary under all insurance plans. Patients (or their parents or guardians, where applicable) are personally responsible for all charges for non-covered services.
- A Claris Vision, LLC accepts cash, checks, and most major credit cards. A $25.00 returned check fee will be charged for any returned checks.

Yearly lens updates and evaluations are required to renew contact lens or eyeglass prescriptions. Lens update and evaluation fees apply even if it is discovered that a patient's vision has not changed. These fees are typically not covered by insurance and are due at the time of treatment.