Eye Care for East Texas

Name: _____ Birth Date: ___/___/_____ Age: ____

Address: _____ Email: _____

City: _____ State:_____ Zip: _____

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____

Employer: _____ Occupation: _____

Primary Care Doctor: _____ Doctors # _____

Social Security Number: _____

Responsible Party for Minors: _____ Social Security Number: _____

To whom information can be released: _____ Relationship: _____Full/Partial

How did you hear about us? _____

About Your Insurance

There are two types of health plans that will help pay for your eye care services and optical products. You may have both types and Dr. Greg Wacasey accepts most insurance plans in both categories. 1) Vision plans (VSP, EyeMed, and others) and 2) Medical insurance (Blue Cross Blue Shield, Aetna, Medicare and others).

- Vision plans only cover routine vision wellness exams, along with eyeglasses and contact lenses. Vision plans do not cover medical eyecare (the diagnosis, management, or treatment of eye health problems).
- Medical insurance must be used for medical eye care.
- If you have both types of plans it may be necessary for us to bill some services to one plan and some services to the other. This will result in the need for two separate visits as we are unable to file on both plans on the same visit.

Any fees not paid by your insurance will be billed to you such as deductibles, co-pays or non-covered services as allowed by the insurance contract.

Please provide your insurance cards to our staff member so we can make a copy. We need to have your medical insurance care or Medicare card on file in case we should need it in the future billing your insurance.

I have read and accept these policies.

_____ _____

Patient Signature (Parent/Guardian if a Minor) Date

PAYMENT IS DUE WHEN SERVICES ARE RENDERED. PROFESSIONAL FEES ARE NON REFUNDABLE. GLASSES EXAM FEE DOES NOT INCLUDE A CONTACT LENS PROSCRIPTION. A FINAL CONTACT LENS PRESCRIPTION WILL BE RELEASED AFTER COMPLETION OF CONTACT LENS FIT PROCESS INCLUDING ALL NECESSARY FOLLOW UP VISITS.

DR. GREG WACASEY THERAPEUTIC OPTOMETRIST

Eye Care for East Texas

FINANCIAL INFORMATION

REFRACTION POLICY

A refraction is a test where a series of lenses are used to determine what lens power will help you obtain your best corrected vision, or you need for corrective lenses (glasses). A refraction is NOT a service covered by Medicare or most medical insurance companies. Our office fee for a refraction is $50.00 and this fee will be collected in addition to any office visit copay.

TRADITIONAL MEDICARE PATIENTS

We file all office visits for Medicare patients. Although we do not file on all Medicare supplements, please be sure to give our office that information. If you supplement is a Medigap Insurance, Medicare will forward your claims directly to that company. If Medicare does not forward your claim, you will be responsible for the 20% that Medicare does not pay plus the cost of refraction and any deductible you have not met at the time of your visit. We will furnish a paid itemized bill for you to send to your supplemental insurance for reimbursement.

MEDICARE HMO PATIENTS

Medicare HMO patients must obtain an insurance referral from your primary care provider prior to each visit. We will not be able to see you without the referral number authorized by your insurance provider.

COMMERICAL INSURANCE PATIENTS

We do not file insurance for office visits unless you are covered by a Preferred Provider Organization (PPO) or Health Maintenance Organization (HMO) with which we are participating. If we are out of your network or if your visit is for a routine vision exam (most insurance companies will not cover a routine vision exam even if it is a PPO or HMO), payment is required at the time of service. We will provide you with the necessary information for you to file for your visit. You will be responsible for any services, tests, or procedures that are denied or not covered by your insurance carrier. It is very important that you check with your insurance carrier or your human resources department at work to determine if your insurance requires you to see a certain doctor or has other special requirements such as a referral number that we must have prior to your upcoming visit. If you should discover that we are not in your plan, please call us as soon as possible so that we may reschedule you. Most insurance companies will not provide us with this information; therefore, we cannot call for you. If you see a doctor out of your network, you usually have to pay a greater portion of the fee and often have a deductible as well.

NO INSURANCE

If you do not have any insurance coverage, payment is required at the time of service.

NOTICE

If for any reason a claim that we file with your insurance carrier remains unpaid sixty (60) days from the date services are provided you will be responsible for payment of the entire balance. Please understand that most insurance companies have a limited amount of days to file a claim, so it is the patient's responsibility to provide us with the correct insurance information before your scheduled appointment. Failure to provide our office with correct insurance information could result in you being responsible for payment of the entire balance from the date of services provided.

By signing below, I acknowledge that I have read and understand Dr. Greg Wacasey's payment policy.

_____ _____

Name Date

DR. GREG WACASEY THERAPEUTIC OPTOMETRIST

Eye Care for East Texas

HIPAA / PRIVACY

Notice of Privacy Practices

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have read the provided copy of Dr. Greg Wacasey's Notice of Privacy Practices.

Patients Name: _____

Signature of Patient: _____

(Or Patients Legal Representative)

Date: _____

I _____ agree to receive my spectacle and/or contact lens prescription electronically.

Missed Appointment and Cancellation Policy

IF YOU ARE UNABLE TO KEEP A SCHEDULED APPOINTMENT, PLEASE GIVE 24 HOURS ADVANCE NOTICE TO ENSURE THAT YOU WILL NOT BE CHARGED FOR THE APPOINTMENT.

IF LESS THAN 24 HOURS NOTICE IS GIVEN AND WE ARE UNABLE TO FILL YOUR TIME SLOT, YOU WILL BE CHARGED A $100 CANCELLATION/NO SHOW FEE.

THANK YOU.

Patient Signature: _____

Date: _____