Clark|Tait
EYE CENTER
Keeping You In Focus

PATIENT INFORMATION

First Name: _____ M.I.: _____ Last Name: _____

Home Phone _____ Cell Phone: _____ Work Phone: _____

Street Address: _____ APT# _____

City: _____ State: _____ Zip: _____ -- _____

Date of Birth: _____/_____/_____ Email Address: _____

Marital Status: Single _____ Married _____ Divorced _____ Widow _____ S.S # _____

RESPONSIBLE PARTY (if other than patient)

First Name: _____ M.I.: _____ Last Name: _____

Home Phone _____ Cell Phone: _____ Work Phone: _____

Street Address: _____ APT# _____

City: _____ State: _____ Zip: _____ -- _____

Date of Birth: _____/_____/_____ Email Address: _____

INSURANCE INFORMATION

Primary Health Insurance: _____

Policy / ID Number _____ Group # _____

Subscriber (Employee) Name: _____ Date of Birth: _____

S.S # _____

Name of Employer (Company): _____

Secondary Health Insurance: _____

Policy / ID Number _____ Group # _____

Subscriber (Employee) Name: _____ Date of Birth: _____

S.S # _____

Name of Employer (Company): _____

Vision Insurance: _____

Policy / ID Number _____ Group # _____

Subscriber (Employee) Name: _____ Date of Birth: _____ S.S # _____

Name of Employer (Company): _____

Please Bring **Completed Paperwork to your appointment. Do NOT mail the paperwork back to our office prior to your appointment.

REFRACTION SERVICE AND FEE

One of the most important parts of you eye exam today is the refraction. This is the part of the exam by which we determine whether you can be helped in any way by a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and look for problems. It is **NOT** a covered service by Medicare and many other insurance plans. These plans consider the refraction a "vision" service not a "medical" service. The current fee for a refraction is ~~$37.00~~ $44 and is due at time of service in addition to any co-payment your plan may require.

** Medicare ONLY Patients

We accept assignment on Part B Medicare patients. You will also be expected to pay your deductible and 20% coinsurance on date of service.

I have completely read all the above information and agree to all the terms.

X _____ _____

Signature of Patient or person acting on patient's behalf Date

FINANCIAL CONTRACT AGREEMENT

Clark Eye Center is committed to your successful treatment. If you do not have your insurance card at the time of your appointment you will be treated as a "self pay" patient.

- **All copays/fees are due at time of service (we accept cash, checks, Visa, MasterCard and Discover)**
- **All "self pay" patients are asked to pay the visit fee in full at time of service unless other arrangements are made (you are given a 20% "self pay" discount)**
- **All delinquent accounts, 30 days past due, may be placed in collections, you may be responsible for all additional charges incurred to collect this account, including court cost and legal fees, along with a $25.00 administration fees.**
- **We DO NOT get involved with any litigation accounts, disputed workmen's compensation cases, divorce decrees or auto accidents; you will be 100% responsible for full payment at time of service or within 90 days of service with a prior arrangement with the billing department.**
- **The adult accompanying a minor or guardians of the minor are the responsible party for payment on the account.**

We accept assignment of benefits for insurance plans that we are contracted with. The balance is your responsibility. Your insurance is a contract between you and your insurance company. We are not party to that contract or know exactly what benefits are included or excluded in your plan. Please be aware that some, and perhaps all the services provided may be noncovered services and not considered reasonable and medically necessary under the Medicare program and/or other medical insurance coverage. We are not liable for any misquoted benefit information.
You are fully responsible for verifying the benefits of your policy.
Clark Eye Center is committed to providing the best treatment for our patients and we charge what is usual and customary in our area. Please let us know if you have any questions or concerns.

I have completely read all the above information and agree to all the terms.

X _____ _____

Signature of Patient or person acting on patient's behalf Date