SALANDVISION

PATIENT INFORMATION

Title:	Last Name:	First:	Middle Initial:	Suffix:	Marital status (circle one) Single / Mar / Div / Sep / Wid

Home Phone: ( )	Alternate Phone: ( )	Preferred: HOME / ALTERNATE	Birth date: / /	Age:	Sex: M F

Street address or P.O. Box:	Social Security #: _____- _____ -_____

City:	State:	Zip:	Parent or Guardian (only if patient is minor):

Employment Status: ☐Full-Time ☐Part-Time ☐Student ☐Retired ☐Not Employed	Occupation & Employer:

Chose clinic because/Referred to clinic by (please check one box):	☐ Referred by Dr. _____

☐ Insurance	☐ Internet	☐ D Magazine	☐ Family / Friend	☐ Other _____

Email addresses will **NOT** be used for any marketing or spam mail, and a secure connection will always be established during transmission to protect the confidentiality of your private health information.

Email: _____

Would you like to receive electronic correspondence from our office (i.e. statements, prescriptions, appointment reminders) ○ Yes ○ No

INSURANCE INFORMATION

Name of Insurance:	Address of Insured Party (If Different From Patient):

Member Name (If Other Than Patient):	Member's Date of Birth:	Relationship to Patient:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Phone number: ( )

The above information is true to the best of my knowledge. I have read and understand the financial policy. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Karen B. Saland, M.D. or insurance company to release any information required to process my claims and/or to provide method of communication with other healthcare providers.

_____ _____

Patient/Guardian signature *Date*

MEDICAL INFORMATION

Patient Name:	**Date:**
Primary Care Physician:	
Pharmacy :	**Pharmacy #:**
Cross Streets & City:	

MEDICATIONS / USE
MEDICATION ALLERGIES:

MEDICAL/SURGICAL HISTORY	**OCULAR (SURGERY / TRAUMA)**	**FAMILY OCULAR HISTORY**
		Glaucoma:
		Retinal Detachment:
		Macular Degeneration:

SOCIAL HISTORY	**REVIEW OF SYSTEMS (PLEASE CHECK ALL THAT APPLY)**		
Smoker: ○ YES ○ NO	☐ Diabetes	☐ Hypertension	☐ Anxiety
Prior Smoker: ○ YES ○ NO	☐ Arthritis_____	☐ High Cholesterol	☐ _____
Drinks Alcohol: ○ YES ○ NO	☐ Lupus	☐ Migraines	☐ _____
	☐ HIV/AIDS	☐ Depression	☐ _____

CONTACT LENS HISTORY

○ None ○ Wore lenses in past; _____ years ago

Current wearer of: ○ SOFT ○ HARD

I use monovision: ○ YES ○ NO

I sleep in my contacts: ○ ALWAYS ○ SOMETIMES ○ NEVER

My ☐ RIGHT ☐ LEFT eye is for distance.

I dispose my contacts: ○ DAILY ○ 2 WEEKS ○ MONTHLY

I wear multifocals: ○ YES ○ NO

My Current Brand / Rx is:_____

PLEASE LIST ANY OTHER HISTORY YOU WOULD LIKE US TO KNOW

FINANCIAL POLICY

The following outlines the financial policies that our office follows. We encourage you to discuss your account, and ask any questions. Your understanding of our policy early on in your treatment process will prevent most concerns and issues in the future.

INSURANCE

- All co-payments and/or coinsurances will be collected at time of service.
- We will file claims on all visits and procedures to your **medical** insurance.
- Accounts will be balanced to match the insurance explanation of benefits (EOB) and any remaining balance will be forwarded to you, the patient.
- You are responsible for **ALL** balances **NOT** paid by your insurance.
- **Please remember insurance coverage is a contract between the patient and the insurance company. The ultimate responsibility for understanding your insurance benefits and for payment to your doctor rests with you.**

REFERRALS

- You are required to:
    1. Know whether or not your insurance requires a referral.
    2. Obtain that referral before you are scheduled to visit our office.
- We will require payment in full on day of service if you do not obtain a referral.

NON-COVERED SERVICES

- Insurance companies will only pay for services that they find "reasonable and necessary".
- You are responsible for payment of any services denied by insurance.

REFRACTION SERVICE AND FEES

- Refraction is the process to determine if there is a need for eyeglasses, and is an essential part of an eye exam. It is considered a routine vision service and performed on all comprehensive annual eye exams.
- Most medical insurance plans, including Medicare, do **NOT** cover routine refractions.
- The fee for refractions is **$65.00** and is collected at the time of the service.

PAYMENT

- Payment may be made by: Cash, Check, Credit/Debit Card, and Money Order.
- Cards Accepted: **DISCOVER**, **MASTERCARD**, **VISA** and **CARECREDIT** (we do not accept AmEx or Diners)
- **A fee in the amount of $35.00 will be charged for all returned checks.**

PAST DUE ACCOUNTS

- Account balances should be handled promptly, and will be considered past due after 120 days with an outstanding balance. All past due accounts will be turned over to a collection agency, and a fee of 2o% of past due balance will be added to your account.
- We will require full payment before seeing the physician for any future services.

PATIENT STATEMENT
OF
FINANCIAL RESPONSIBILITY

Please initial each statement to acknowledge that you have read and agree.

_____ I acknowledge that I have been informed of Saland Vision's financial policy.

_____ I understand that my insurance company may deny payment for my office visit for the reasons stated in the financial policy.

_____ I recognize that I am personally and fully responsible for payment of any services denied by insurance.

_____ I agree to the terms of this Financial Policy.

_____
Print Patient's Name

_____ _____
Signature of Patient/Guardian *Date*