Patient Demographic Information

Please print:

Patient Name:			Social Security #:	DOB:	Age:	Sex: M F
Mailing Address: Street			City:	State:	Zip Code:	
Home Phone:	Work Phone:	Cell Phone:	Preferred method of contact: ☐ home ☐ cell ☐ work	e-mail address:		
Employer:		Marital status: S☐ M☐ D☐ W☐	Spouse Name:	Spouse Phone:	Spouse DOB:	
Emergency Contact:			Relationship:	Phone:		
Primary Care Physician:			Optometrist:			

Complete if under 21 or a student:

Guarantor Name:	Phone:	Date of Birth:	Employer:
Mailing Address: Street	City:	State:	Zip Code:

Insurance Information:

Primary Insurance Name:	Policy #:	Policy Holder Name: ☐ same as patient
Secondary Insurance Name:	Policy #:	Policy Holder Name: ☐ same as patient
Vision Insurance Name:	Policy #:	Policy Holder Name: ☐ same as patient
Vision Policy Holder Birthdate: ☐ same as patient	Vision Policy Holder Social Security #: ☐ same as patient xxx – xx - _____	

Government Required Information (check ONE in each section)

Race		Ethnicity	Primary Language
☐ American Indian or Alaska Native	☐ White	☐ Not Hispanic or Latino	☐ English
☐ Black or African American	☐ Asian	☐ Hispanic or Latino	☐ Spanish
☐ Native Hawaiian or other Pacific Islander	☐ Other Race	☐ Unknown	☐ French
	☐ Declines to answer	☐ Declines to answer	☐ Other

Medicare Patients ONLY:

How are you enrolled in Medicare? ☐ based on age ☐ based on disability ☐ based on ESRD (end stage renal disease)

Is Medicare your primary or secondary insurance plan? ☐ primary ☐ secondary

Y ◯ N ◯ Are you receiving Black Lung (BL) benefits? If yes, date benefits began _____

Y ◯ N ◯ Are your services at ClearView to be paid by a government program such as a research grant?

Y ◯ N ◯ Are your services at ClearView to be paid by Dept of Veterans Affairs (DVS)?

Y ◯ N ◯ Are you currently employed?

Y ◯ N ◯ Is your spouse employed? If yes, employer _____

Y ◯ N ◯ Do you have group health coverage based on your own or a spouse's current employment? If yes, does that employer that sponsors the group health coverage have 20 or more employees? Y◯/◯N

ClearView
EYE CLINIC

Acknowledgement of Privacy Practices (HIPAA) and Financial Responsibility

Acknowledgement of Financial Responsibility: I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for all fees incurred in my treatment and services. I authorize the doctor or insurance company to bill my insurance and release any information required for this claim. I authorize ClearView to use automated phone calls and/or automated text messages to communicate with me regarding my account.

Privacy Notice Confirmation: I understand that by signing below, I am certifying that I have been offered the Notice of Privacy. I understand that I have the right to review the notice prior to initialing. I understand that the CVEC reserves the right to change their notice and practices and will publish any changes in the lobby. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand, that unless I object, CVEC may disclose protected health information to a member of my family, relative, close friend, or other person who is involved in my healthcare or payment of my healthcare. CVEC will limit the disclosure to the protected health information relevant to that person's involvement in my healthcare or payment.

Consent for Treatment: I hereby give my consent for the authorized personnel of ClearView Eye Clinic (CVEC) to evaluate and, if appropriate; render subsequent treatment in accordance with the plan of care authorized by my physician (if applicable) or by my personal authorization.

Consent for Minor: As the named minor's parent or legal guardian, I hereby give my consent for the authorized personnel of ClearView Eye Clinic to evaluate and, if appropriate, render subsequent treatment in accordance with the plan of care authorized by patient's physician (if applicable) or by my personal authorization.

Refraction: As part of your examination, a refraction may be performed. Many insurances, including Medicare, do not cover this test. If a refraction if performed, you will be responsible for the cost. The fee is $40 and due at the time of service.

Contact Lens Evaluation & Fitting: Both new and existing contact lens wearers will have a contact lens evaluation and fitting as part of the examination. Your insurance may not cover this service. If insurance does not cover, it is due at the time of service. The fee is $40.00 for existing wearer, $85-145 for new wearer depending on type of lens needed.

I have read and understand the above information. I understand I am responsible (regardless of my insurance) for any charges incurred from services rendered.

Primary Care Physician Name: _____

Signature: _____ Date: _____

Parent/Other: _____ Relationship: _____

ClearView
EYE CLINIC

Billing Policy

Because patients often have both medical and vision insurance, it is important to understand the difference.

Vision insurance does not cover medical eye problems, just as most medical insurance does not cover routine vision problems.

Vision Insurance

- Covers routine eye examinations only
- Helps to pay for glasses or contact lenses

If you have a vision hardware benefit, it is your responsibility to be aware of the benefit and its limitations. We may bill your insurance plan, but there is no guarantee of payment. In the event of non-payment, you are responsible for the fees once an order is placed.

Medical Insurance

- Diabetes
- High Blood pressure
- Taking high risk medications
- Eye disease
- Lazy eye
- Infections
- Glaucoma
- Dry eyes
- Allergies
- Macular degeneration (ARMD)
- Cataracts

After your examination, the doctor will determine to which insurance the exam will be filed. Glasses and/or contact lenses might still be filed to your vision insurance if the exam is filed to your medical insurance. If we are a provider for your insurance, we will file a claim to your primary insurance carrier. However, in the event we are not on your provider's panel, we will provide an itemized receipt so you may file the claim for yourself.

I understand the information above and authorize ClearView Eye Clinic to file a claim with my insurance.

Signature: _____ Date: _____

Parent/Other: _____ Relationship: _____