CHIPPEWA VALLEY EYE CLINIC ***PLEASE BRING COMPLETED FORMS & INSURANCE CARDS TO YOUR APPOINTMENT***

PATIENT INFORMATION

Marital Status: Single / Married / Divorced / Widowed

Name _____ Date of Birth _____ Sex: M / F / Decline

Address _____Apt/Lot#_____ Phone (H)_____(W) _____

City/State/Zip: _____ Cell Phone _____

Social Security # _____ Employer _____

Email _____ Occupation _____

Race _____ Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other _____

Language: ☐ English ☐ Spanish ☐ Hmong ☐ Other (specify) _____

GUARDIAN / GUARANTOR INFORMATION – Must be filled in for patients under 18

Name: _____ Date of Birth: _____ Email: _____

Address: _____Apt/Lot#_____ Phone: (H)_____(W) _____

City/State/Zip: _____ Cell Phone: _____

Social Security #: _____ Relationship to Patient: _____

PRIMARY INSURANCE Name: _____

ID# _____ Grp# _____

Subscriber Name:_____

Relationship to Insured: Self / Spouse / Child / Other

Subscriber SS#: _____ Birth Date: _____

Employer: _____

SECONDARY INSURANCE Name: _____

ID# _____ Grp# _____

Subscriber Name: _____

Relationship to Insured: Self / Spouse / Child / Other

Subscriber SS#: _____ Birth Date: _____

Employer: _____

VISION INSURANCE Name: _____ ID# _____

Subscriber Name:_____ Subscriber Date of Birth: _____

WORKER'S COMPENSATION INFORMATION - Is this a Work Comp visit? YES / NO Date of accident: _____

Emergency Contact: _____ Relationship:_____ Phone:_____

PHI Release Authorization: I grant Chippewa Valley Eye Clinic permission to share my medical records, treatment, & billing info to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

HIPAA NOTICE: Chippewa Valley Eye Clinic's Notice of Privacy Practice is available at www.cveclinic.com/Patient-forms . I acknowledge that a printed version has been offered to me and is also available at my request.

I CERTIFY THAT THE INFORMATION I HAVE SUPPLIED REGARDING MYSELF OR MY DEPENDENT IS ACCURATE AND COMPLETE.

_____ _____

Patient / Guardian Signature **Date**

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SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

*In return for the services, I receive and/or have received from Chippewa Valley Eye Clinic ("**Provider**"), I agree to:*

1. **Assignment of Benefits** Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to Chippewa Valley Eye Clinic for any services furnished to me by their physicians. If co-payments and/or deductibles are designated by my insurance company or my health plan I agree to pay them to Chippewa Valley Eye Clinic. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill. The undersigned agrees to be individually obligated to pay the full charges of all services rendered by Chippewa Valley Eye Clinic, if I belong to a plan that is not on their list of contracts. These assigned, transferred rights include, but are not limited to:
   a) The right to receive payment for any medical bills incurred because of services provided by Provider.
   b) The right to information about My Coverage, including but not limited to information about plan features/ funding.
   c) The right to appeal any adverse benefit determination or other denial.
2. **Cooperation** I agree to cooperate with Provider to pursue all available remedies, benefits, payment. I agree to fulfill any reasonable request from Provider i.e., signing correspondence or obtaining information about My Coverage from my employer or insurer. I agree that no guarantees have been made to me as to the results of examination/treatment provided to me by Provider.
3. **Insurance, Health Benefits Coverage, and/or Medical Assistance** It **is my responsibility to provide Provider with current and accurate My Coverage and/or medical assistance program(s) information at the time of service**. I certify that the information given by me under My Coverage and/or medical assistance program(s) is correct. I authorize Provider to release any information about me which is properly needed for processing and paying My Coverage and/or medical assistance program(s) claims.
4. **Responsibility for Payment** I understand that am responsible for all amounts not otherwise paid, in whole or in part, by My Coverage, including but not limited to **co-payments, deductibles, co-insurance,** & **non-covered services** under My Coverage. I agree to pay for all charges that are due for my care/treatment by Provider in accordance with Provider's regular rates/terms. I agree to **pay any co-payments at the time of service**. I also understand that I am responsible for paying Provider in full for services My Coverage will not cover due to non-payment of any premiums required by My Coverage. I understand that although Provider may file claims with My Coverage as a courtesy to me, I am ultimately responsible to pay for the services received. We gladly accept cash, personal checks, Care Credit, and most major credit cards. Returned Checks will be subject to a $25 fee.
   - **Self-Pay** Fees will be discounted only when paid on the date of service.
5. **Delinquent Accounts** Unpaid accounts will receive 2 monthly statements; a reminder letter; and a final notification of transference of the debt to a collection agency if no attempts at payment or contact to the clinic are made.
6. **Communication privacy notice** By supplying my home phone number, cell phone number, email address, I authorize my health care provider to employ a third-party automated messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, collections, or any other healthcare related function. I consent to allowing the above detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.
7. **Disclosure of Information for Care Purposes** I hereby permit Chippewa Valley Eye Clinic to use my health information and/or to disclose my health information to any third-party payer or any party involved in my health care.
   - I understand that I can revoke this consent in writing at any time.
8. **Refraction & Contact Lens Prescriptions:**
   Refraction is the process of determining the eye's refractive error or need for corrective lenses. It is sometimes necessary to determine if visual complaints are due to the need for glasses or a medical problem. Chippewa Valley Eye Clinic charges $50 for refraction. This charge is not covered by Medicare and most commercial insurances that do not have a Vision Benefit. If this service is not covered by your insurance plan, you will be responsible for payment.
   Contact Lens Prescriptions/Fitting is a yearly fee associated with the proper fitting and prescription of contact lenses. Prices vary depending on the type of prescription you require. This service is required to get an accurate prescription for contacts.

I certify that I have read and understand this Agreement and had the opportunity to ask questions. For a minor patient, I attest that he/she is a beneficiary under My Coverage; I sign as a parent/guardian as the person financially responsible for payment of medical bills.

_____ _____

Patient / Guardian Signature **Date**