COUNCIL EYE CARE INC.
4243 TRANSIT ROAD
WILLIAMSVILLE, NY 14221

REGISTRATION

Welcome to Council Eye Care. We ask that you provide us with your most current information. Please fill out the entire form. This is so we can provide you with the best of service. If you are an existing patient with us, we appreciate your patience and understanding as we update all of our files as necessary. Thank you.

PATIENT INFORMATION

Mr. /Mrs./Miss/Ms./Dr._____ _____ _____
FIRST NAME MI LAST NAME

_____/_____/_____ M / F _____ SINGLE / MARRIED / DIVORCED / WIDOWED
DATE OF BIRTH SEX SOCIAL SECURITY NUMBER MARITAL STATUS

_____ _____ NY _____
STREET ADDRESS CITY ZIP

_____ _____ _____
HOME PHONE # WORK/DAYTIME PHONE# CELL PHONE #

EMPLOYMENT STATUS: EMPLOYED FT / EMPLOYED PT / FT STUDENT/ PT STUDENT / NOT EMPLOYED / RETIRED

EMAIL ADDRESS: _____

PRIMARY CARE PHYSICIAN: _____ PHONE:_____
PHARMACY: PHONE: ADDRESS:

INSURANCE INFORMATION– PLEASE GIVE YOUR INSURANCE CARD TO STAFF FOR COPYING. PLEASE INDICATE

THE PRIMARY INSURANCE: __BLUE CROSS BLUE SHIELD ___SENIOR BLUE __VSP __ INDEPENDENT HEALTH
__MEDICAID __MEDICARE __NVA __UNIVERA ___EYEMED ___VBA__OTHER_____

_____ _____ _____
SUBSCRIBER (PRIMARY INSURANCE HOLDER) SUBSCRIBERS DOB SUBSCRIBERS SS#

GUARANTOR INFORMATION (FINANCIAL RESPONSIBLE PARTY)

_____ _____ _____
NAME ADDRESS PHONE

RELATION TO PATIENT: _____

DISCLAIMER

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Council Eye Care Inc or insurance company to release any information required to process my claims.

_____ _____
PATIENT OR GUARDIAN SIGNATURE TODAY'S DATE

COUNCIL EYE CARE INC
4243 TRANSIT ROAD
WILLIAMSVILLE, NY 14221

FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility.

- All patients must complete our "Registration Sheet".
- Full payment is due at the time of service.
- All co-payments are due at the time of service.
- Past due accounts are subject to a monthly 2% interest fee after 90 days.
- Past due accounts are subject to a 33% collection fee once they are sent to collections.
- Patients utilizing vision plans are subject to their return policies. (VSP and Eyemed fabricated eyewear is not returnable.)
- Frames and lenses may be returned for store credit only within 30 days of purchase and are subject to a 15% restocking fee on the full retail price.
- We accept cash, check, Visa, MasterCard, Discover and American Express. Returned checks will have an additional charge of $25.00.

REGARDING INSURANCE

If you have insurance, we will help you receive maximum benefits. However, **INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY.** We will inform you if we participate with your insurance company, and will handle your claims according to our agreement with them, if one exists. We file insurance claims as a courtesy to our patients. We WILL NOT become involved in disputes between you and your insurance company regarding deductibles, co-payments, referrals, covered charges, secondary insurance, "usual and customary" charges, etc. other than to supply factual information as necessary.

REGARDING APPOINTMENTS

Once you have made an appointment with us, it is your responsibility to inform us of your current insurance information. If you are seen by our office and have not informed us of any changes that may have occurred with your insurance, you will be charged and expected to pay for the full office visit. You may then submit your receipt on your own to your insurance company for reimbursement.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY

PATIENT/GUARDIAN SIGNATURE_____ DATE _____

COUNCIL EYE CARE INC.
4243 TRANSIT ROAD
WILLIAMSVILLE, NY 14221

BILLING POLICY

Dear Council Eye Care Inc. Patient:

You are scheduled for your annual routine eye exam appointment and we would like to inform you of our billing policy which mirrors local and national insurance plan policies.

A routine eye exam is a once a year visit to our office to see an Optometrist for a general health check of the eyes and to update a prescription for glasses. Some health plans cover a set of preventative services, such as the routine eye exam at little to no cost to you.

The routine eye exam includes:

- A general health check of the eyes
- Review of allergies and current medications
- An updated eye glass prescription to meet current visual needs

A routine eye exam does not include the discussion of new problems or detailed review of and/or management of chronic conditions. While the appointment may have been scheduled as a routine eye exam, if a problem or chronic problem is addressed and/or treated during your visit, services may be billed medically. We are legally obligated to report diagnostic procedure codes based on the services provided to you, whether it is a "routine eye exam", a visit to address and treat medical problems, or both. This billing standard could possibly create additional out-of-pocket expenses to you, such as a copay or deductible, based on your individual insurance plan. If you prefer to have your eye exam addressed and billed strictly as a preventative service, a separate follow up visit to address medical concerns can be scheduled and billed accordingly.

Examples of medical problems:

- Abnormal significant findings requiring additional treatment and care outside of the routine eye exam
- Any significant complaint, change and/or management of chronic conditions outside of the routine exam requiring additional treatment

We thank you for your cooperation as Council Eye Care Inc. strives to comply with all local and national insurance billing standards and guidelines. We aim to provide exceptional quality care to all our patients and thank you for trusting us with your vision. Please sign below to acknowledge you have read and understand our billing policy.

_____ _____

Patient/Guardian Signature **Date**

COUNCIL EYE CARE INC.
4243 TRANSIT ROAD
WILLIAMSVILLE, NY 14221

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Council Eye Care, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Council Eye Care, Inc. may use my health care information and may disclose such information to the insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable to related services.

Patient/Guardian Signature_____ Date _____

COUNCIL EYE CARE INC
4243 TRANSIT ROAD
WILLIAMSVILLE, NY 14221

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (Patient), date of birth _____, Social Security Number _____, acknowledge and agree that I have received a copy of the Council Eye Care Inc. Notice of Privacy Practices.

_____ _____
Patient/Guardian Signature Date

_____ _____
Print Name of Guardian (if applicable) Relationship (if applicable)

If this acknowledgment is signed by someone who is not the patient listed at the top of this form, provide a description of the signer's authority to act for the patient:

_____

_____

FOR OFFICE USE ONLY:

Council Eye Care Inc made the following good faith efforts to obtain the above-referenced individual's written acknowledgment of receipt of the Notice of Privacy Information Practices:

( ) Patient/Guardian was offered copy and individual refused to accept delivery
( ) Patient/Guardian accepted delivery of copy but refused to sign form to acknowledge Receipt of Notice.
( ) Other

_____ _____
Staff Member Signature Date