



Today's Date: \_\_\_\_\_

PATIENT INFORMATION

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_

I PREFER TO BE CALLED: \_\_\_\_\_ PRIMARY LANGUAGE: \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ MALE/FEMALE

MAILING ADDRESS \_\_\_\_\_  
Address City State Zip

STREET ADDRESS \_\_\_\_\_  
Address City State Zip

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

WORK PHONE \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

PRIMARY DOCTOR \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_  
Name Phone

WHO REFERRED YOU TO OUR OFFICE? \_\_\_\_\_  
(Name of family physician, internist, optometrist, friend, yellow pages, etc.)

PATIENT INSURANCE INFORMATION

In order to insure accurate insurance information, we require your current insurance cards to scan.

• PRIMARY INSURANCE CO NAME \_\_\_\_\_

POLICY HOLDER NAME \_\_\_\_\_ POLICY HOLDER DOB \_\_\_\_\_

• SECONDARY INSURANCE CO NAME \_\_\_\_\_

POLICY HOLDER NAME \_\_\_\_\_ POLICY HOLDER DOB \_\_\_\_\_

PERSON RESPONSIBLE FOR PATIENT

NAME \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_  
Street or PO Box City State Zip

(SIGNATURE REQUIRED ON BACK OF FORM)

## Lifetime Signature on File, Assignment of Benefits, Financial Agreement

**We are committed to providing you with the highest level of service and quality care.**

**We expect, in turn, that you have the same commitment to your financial responsibility to us.**

**1. MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to **ARVADA VISION & EYE CLINIC, PC** (referred to as AVEC) for services furnished me by AVEC. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. Coinsurance and deductible are based upon the final determination of the Medicare Carrier and are my responsibility.

**MEDICARE ADVANTAGE PLANS:** I agree to provide appropriate information regarding my Medicare Advantage Plan to ECNC as this may affect coverage for services provided. If I fail to provide accurate and timely information to ECNC, I agree to be fully responsible for payment.

**2. SUPPLEMENTAL INSURANCE:** With current information, AVEC will file my supplemental insurance claim on my behalf. My signature below authorizes release of the information to the insurance company. I request that payment of authorized secondary insurance benefits be made on my behalf to AVEC. If my supplemental insurance plan pays me directly, I agree to remit said payment immediately to AVEC.

**3. RELEASE OF INFORMATION:** AVEC may disclose all or any part of my medical record and/or financial ledger to any person or corporation which is or may be liable or under contract to AVEC for reimbursement for services rendered, and to any health care provider for continued patient care. A copy of this authorization may be used in place of the original.

**4. OTHER INSURANCE:** AVEC participates with most major insurance plans and will make a reasonable effort to notify me if AVEC has no contract, expressed or implied, with my particular insurance plan. Notification may be verbal or by signage. However, it is ultimately my responsibility to understand my insurance plan's coverage, benefits and limitations. I agree to be responsible for all items or services rendered by AVEC regardless of insurance coverage, and I accept full financial responsibility if incorrect or untimely insurance information is given by me to AVEC.

**5. NON-COVERED SERVICES:** I understand that AVEC's contracts with insurance plans relate only to items and services which are covered by the insurance plans, and that AVEC does not determine what defines a covered benefit of my insurance company and cannot make any guarantees about coverage. That determination is made only by my insurance plan after the claim is received. Accordingly, the undersigned accepts full financial responsibility for all items or services which are determined by the health care service plans to be non-covered. Examples of non-covered items may include services considered to be routine, cosmetic, preexisting or experimental, and treatment or tests not recognized by the health care service plan.

**6. FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by AVEC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to AVEC for payment. Copays not paid at time of service are subject to a \$10.00 billing fee. Repeat statements are subject to a \$10.00 billing fee. **MINOR CHILDREN:** EAVEC is not party to any divorce or custody arrangement, therefore the parent accompanying the minor child is responsible for payment. **COLLECTIONS:** If an account is sent to an agency for collection, I agree to pay all collection expenses and reasonable attorney's fees as established by the court. I understand and agree that if my account is placed for collection, I will be charged a delinquent account fee based on my account balance as follows: for balances up to \$100.00, the fee added is \$25.00. From \$101.00 to \$500.00, the fee added is \$50.00. From \$501.00 to \$1000.00, the fee added is \$75.00. For balances over \$1001.00, the fee added is \$100.00. Delinquent account fees are not negotiable. Non-payment of accounts may result in termination from the practice. Account disputes must be received within 60 days of first statement date. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to AVEC.

**It is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill regardless of insurance coverage.**

Beneficiary or Authorized/Responsible Party Signature

Date