Joliet EyeCare Associates Dr. Tahir & Staff

Thank You for Choosing Us and Welcome

About You – The Patient

Date:_____/_____/_____

Last:_____

First:_____ MI: ____

Birthday: _____/_____/_____ **Sex:** ◯ M ◯ F

Social Security #: _____-_____-_____

◯ Single ◯ Married ◯ Other

Address:_____

City:_____ State: _____ Zip: _____

Driver Lic. # _____

Employed: ◯ Full ◯ Part ◯ Retired ◯ Student

Employer Name:_____

Person Responsible for this account

◯ Me ◯ Spouse ◯ Mom ◯ Dad ◯ Guardian

Last:_____

First:_____ MI: ____

Birthday: _____/_____/_____ **Sex:** ◯ M ◯ F

Social Security #: _____-_____-_____

◯ Single ◯ Married ◯ Other

Address:_____

City:_____ State: _____ Zip: _____

Driver Lic. # _____

Employed: ◯ Full ◯ Part ◯ Retired ◯ Student

Employer Name:_____

Ways to Contact Responsible Party for this Account

Phone # (**)** _____ ◯ Cell - perferred method ◯ Home

EMAIL

Used for receipts, appointments, confirmations, recalls, glasses, contacts, office info only

Your Insurance (Must be Present Before Your Visit)

Medical: _____

◯ PPO ◯ HMO ◯ None - Private Pay

Vision: _____

⊗ None - Private Pay

Your Doctors

Primary Physician: _____ Location: _____

Diabetic Doctor: _____ Location: _____

RA Doctor/Other: _____ Location: _____

Texts - Emails

How did you hear about us: ◯ Google ⊗ Facebook ◯ Other: _____

◯ Yes ◯ No Can leave information regarding appointments, products, billing, results- contacting you via text, email, voicemail. Some information maybe sensitive as diagnosis, codes, billing, etc.

◯ Yes ◯ No Can we leave information with another family member . Who ? _____

In case of Emergency - who should we contact

Name: _____ Relationship: _____ Ph: ( )_____

Screening Tests to Rule Out Diseases

5 MINUTES & PAINLESS

STATE OF THE ART TESTING, including 3D LASER RETINAL SCAN help to pickup EARLY CAUSES of vision loss including …

- Diabetes
- Glaucoma
- Macular Degeneration
- Strokes
- Hypertension
- Retinal Detachment
- Cataracts
- UV Damage
- Floaters

and more…

3 SCREENING TEST

ONLY $78.00

(Saving over 40%)

◯ Yes ◯ No

DILATION

Basic (non-medical based issues) dilation included w/ wellness visit.
4-6 hrs. blurry vision. All NEW patients are required to have a dilation.

◯ **Yes** Dilation today

◯ **No** I assume ALL risks of eye diseases including blindness.

◯ **Yes** but reschedule $60.00

** Specialty dilation/testing for LASIK and children under 10 - additional.*

OFFICE POLICY - PAYMENT - INSURANCE

- **CREDIT CARD:** Required for any medical claims billed to your medical insurance (or deposit on file).
- **CHARGES:** Co-pays, deductibles, co-insurance, balances, out of pocket tests (refractions, preventative testing, etc.) are due at the time of service. Medical nor vision insurance guarantees payment. You give permission to submit claim(s), release information regarding your care to necessary entities and payment directly to Joliet EyeCare Associates (JEA). Your are responsible for all remaining charges.
- **INSURANCES:** You are responsible for knowing your insurance, coverage, and network status before your visit. Some PPO and most HMO insurance require pre-authorization. All insurances must be present before your visit (vision, medical, etc). $25 charge for resubmission or submitting a claim after the fact. Amount paid will be directed to you. No refund on amounts already paid to JEA. JEA does not coordinate benefits between medical and vision insurances (ex: glasses script - refraction). If any insurance does not pay within 60-days of submission you are responsible for the amounts owed.
- **HIPPA:** You have reviewed a copy of the HIPPA privacy law; hard copy available upon request.
- **DILATION:** other testing maybe covered today pending insurance/reason. Postponed testing incurs a $60 charge and completion of test(s) must be done within 30-days. All new patients- dilation mandatory.
- **PAYMENT - COLLECTIONS - RETURNED CHECKS:** If sent to collections, 33% above total fee and all other fees; attorney, courts, etc. NSF checks - $35 service fee plus money owed and account will be placed on a cash or credit card only basis 1-3 years. Late fees - 10% of balance owed monthly.
- **RECORDS - FORMS - LETTERS:** Charges for copying medical records being released to patient (amount to be determined upon request). Specialty forms or letters incur a charge of $15-$50.
- **CUSTOM PRODUCTS:** Eyeglass, lenses, and/or contacts are custom made for you and your prescription in a frame you choose. We can remake your lenses one time before 45-days from notification, if a problem arises. If a return is required, regardless of insurance, a 15% restocking fee is assessed and store credit is given. No returns will be accepted after 45-days. There is never a refund on any services performed.
- **PROBLEMS:** Changes/rechecks on glasses, contacts, etc. must be presented within 45 days of your exam/notification or additional charges will apply.
- **PRODUCT PICKUP - UNCLAIMED ITEMS PAST 45-DAYS: :** Product MUST be picked up within 45-days of notification. Product past 45-day will be shipped to the address on file charged at $20.00 shipping to your CC on file or due at your next appointment. No refunds and not responsible for shippers errors.
- **MISSED OR CANCELED APPOINTMENTS:** $55 charge for all missed appointments not canceled within 24-hours.
- **WARRANTIES:** 1-year warranty on most frames/lens (pending product selection and lens treatments). Lost or stolen is not covered. To utilize warranty broken pieces (frame/lens) must be returned.

Signature (Responsible for Account): _____

Print Patient Name: _____ Date:____/_____/_____

- CREDIT CARD ON FILE -

REQUIRED FOR MEDICAL CARE - RECOMMENDED FOR VISION

AFTER YOUR INSURANCE PROCESSES UP TO 2 STATEMENTS WILL BE SENT

BALANCE $40.00 OR LESS

- Credit card **AUTOMATICALLY BILLED.** Receipt sent upon request or email on file.

BALANCE OVER $40.00

- **STATEMENT SENT** - payment due within 14-days (ex. cash, check, charge, online, etc).
- **Payments not received after 14-days, card on field charged full amount.**

OTHER

- 10% late fee assessed after 14-days and per month
- Collections after 60 days. Patient assumes all collection fees (33% plus court, attorney etc).

CARD STORED AT CHECKOUT

CARD TYPE: ◯ VISA ◯ MasterCard ◯ Discover ◯ Care Credit ◯ Debit ◯ Flex Spending

CC Number: XXXX-XXXX-XXXX- | | | | | **EXP. DATE:** _____/_____

OTHER PATIENT(s) CARD IS APPROVED FOR:

NAME	Relationship
1)	
2)	
3)	
4)	

I understand I am responsible for all remaining balances including: co-pays, co-insurances, deductibles, denials and any non-covered service as deemed by my insurance(s) or office policy. Remaining balance of $40.00 or less is **automatically charged** to my credit card on file and a receipt can be requested or will be emailed.

I authorize Joliet EyeCare Associates to keep this information on file (through the credit card processor - not in office) and charge my card for payment and refund purposes only.

_____ Signature of Card Holder

__/__/__ Date

PRINT SAVE