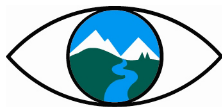


WELCOME TO OUR OFFICE

Thank you for choosing our office. In order to serve you properly, please provide the following information. All information is private and confidential and is only used for identification, insurance use, and appointment communication. It is not shared and is HIPAA compliant.

Patient Name:_________________________________ Gender:______ Today's Date: ______/______/______

Address:_____________________________________ City:_________________ State:______ Zip:________

Email:____ DOB______/______/______

Cell Phone: (______)________________________ Home Phone: (______)___________________________

Driver's License#________________ SS#__________________ Marital Status: ☐single ☐married ☐divorced

If patient is a child, who may authorize treatment?_________________________ Relationship:__________________

Occupation:____________________ Employer Name:__________________ Work Phone: (______)____________

Emergency Contact Name:_______________________________ Phone: (______)________________________

Do you have Vision Insurance? ☐ Yes ☐ No Do you have Medical Health Insurance? ☐ Yes ☐ No

Race: ☐ Amer. Indian ☐ Asian ☐ African Amer./Black ☐ Declined ☐ Hispanic ☐ Pacific Island ☐ White

Ethnicity: ☐ Declined ☐ Hispanic ☐ Pacific Island ☐ Not Hispanic or Latino

Whom should we thank for referring you?____

VISION INSURANCE (Insurance companies require the below information for billing purposes.)

Name of Insured:____________________________ Relationship to Patient: ☐ self ☐ spouse ☐ parent ☐ guardian

Insured's Social Security #________________________ Insured's DOB ______/______/______

Insurance Co. Name:___________________________ Policy # :__________________

MEDICAL HEALTH INSURANCE

Name of Insured:___________________________ Relationship to Patient: ☐ self ☐ spouse ☐ parent ☐ guardian

Insured's Social Security #________________________ Insured's DOB ______/______/______

Insurance Co. Name:___________________________ Policy # :__________________

ADDITIONAL INSURANCE

Name of Insured:____________________________ Relationship to Patient: ☐ self ☐ spouse ☐ parent ☐ guardian

Insured's Social Security #________________________ Insured's DOB ______/______/______

Insurance Co. Name:___________________________ Policy # :__________________

I authorize the release of any information concerning my (or my child's) healthcare, to expedite insurance payment. I also hereby authorized payment of insurance and understand that I am responsible for all charges, regardless of insurance coverage.

Patient/ Parent/ or Legal Guardian Signature:____________________________________Date:______/______/______

FINANCIAL POLICY

We may bill your insurance company as a courtesy to you. Please provide your current Insurance Information on our Welcome Form.

You are responsible to pay the estimated balance your insurance will not cover. This balance is due at the time of service.

The following terms are accepted:

1. Payment for services rendered is due in full on the date of service.
2. Payment for materials is due the date of the order.
3. We accept cash, checks, debit/credit cards, and CareCredit Financing.
4. An interest fee will be added to all overdue balances, and if collection on my account becomes necessary, a fee will be added to my balance.
5. There is a $25 charge on all returned checks with non-sufficient funds.

LIFETIME INSURANCE AUTHORIZATION

_____ (Initial) I understand Boise Mountain Eyecare will verify my eligibility and benefits information.

_____ (Initial) I understand this does not guarantee payment by the insurance company.

_____ (Initial) I request that payment of authorized benefits from Medicare or other insurances or programs be made either to me or on my behalf to Boise Mountain Eyecare for any products or services furnished to me.

_____ (Initial) I also authorize any holder of medical information about me to release any information needed to determine these benefits or benefits for related services.

_____ (Initial) I understand that I am financially responsible for all charges whether or not paid by my insurance company.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY, FINANCIAL, AND HEALTH INFORMATION EXCHANGE POLICIES

_____ (Initial) I have received and read a copy of the “Notice of Privacy Policy” of this office and understand my rights regarding my Protected Health Information (PHI) according to the rules and regulations set forth by the Health Insurance Portability and Accountability Act (HIPAA).

____ (Initial) I understand that Boise Mountain Eyecare is compliant with all required government health information exchange laws allowing you to access your health information. This is a private and secure service designed to put patients in control of their health information. After your appointment, you will receive an email giving you the option of enrolling.
If you have any questions, please ask our staff.

Patient/Parent/Guardian Signature______________________________Date:______/______/______

BOISE MOUNTAIN EYECARE

Personalized Eyecare For The Entire Family

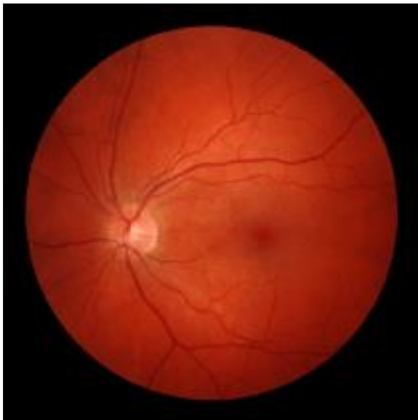
In our continued efforts to bring the most advanced technology available to our patients, Boise Mountain Eyecare is proud to recommend the **Optos Digital Retinal Imaging Camera** as an integral part of your exam today.

This procedure consists of taking a photograph of the back part of the eye (retina), and is suggested for both adults **and** children.

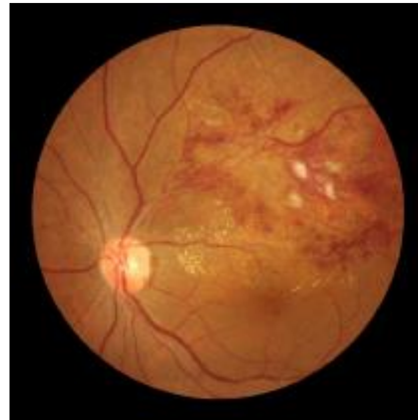
This latest high-resolution camera offers the best detailed images possible and is very valuable in assessing the health of your eye and safeguarding the health of your eye against:

- diabetic retinal disease
- macular degeneration
- retinal detachments and holes
- high blood pressure retinal disease
- glaucoma
- floaters

HEALTHY



UNHEALTHY



- In most cases, dilation is not needed for retinal photos.

The fee for this additional part of your eye exam is $39.00.

□ **YES**, I consent to retinal photos.

□ **NO**, I DO NOT consent to retinal photos.

Patient Signature___________________________Date_________________