



PREMIER EYE

ASSOCIATES

PATIENT INFORMATION	
First Name:	Last Name:
Preferred Name:	Phone Number:
Email:	Date of Birth:
Social Sec #:	Occupation:
Marital Status:	Sex:
Address:	City:
State:	Zip:

PARENT / GUARDIAN INFORMATION (IF UNDER 18)	
Name:	Phone:
Relationship to patient:	

HEALTH INSURANCE POLICY HOLDER INFORMATION	
Policy Holder's First Name:	Policy Holder's Last Name:
Relation to patient:	Social Sec #:
Sex:	Date of Birth:
Address:	City:
State:	Zip:

VISION INSURANCE POLICY HOLDER INFORMATION	
Policy Holder's First Name:	Policy Holder's Last Name:
Relation to patient:	Social Sec #:
Sex:	Date of Birth:
Address:	City:
State:	Zip:



POLICIES & PRACTICES

CANCELLATION FEE: We require 24 hours' notice if you are not able to keep an appointment. We reserve the right to charge a cancellation fee to patients who miss appointments or reschedule within 24 hours of their appointment.

COMMUNICATION: I consent to allow office staff to call, text, or email me.

CONSENT FOR TREATMENT: I authorize Premier Eye Associates to perform any necessary services that I may need during diagnosis and treatment.

GLASSES REMAKES: All remakes must be requested within 30 days of the dispense date. Glasses are eligible for 1 free remake and refraction within 30 days. If you wish to have further remakes, you will owe a 50% fee (50% of the retail cost of the lenses) per remake as well as a Refraction fee if you would like to have your prescription checked again.

LATE PAYMENTS: For each month over 30 days past due a 10% late fee will be added to outstanding balances. After 60 days past due all outstanding balances will be sent to collections. A 33% above total fee will be applied to all invoices sent to collections. Patient assumes all attorney fees related to collecting outstanding balances.

INSURANCE: At Premier Eye Associates, we happily submit claims to your insurance company. We do our best to estimate your insurance coverage and out of pocket costs, but please remember that it is just an estimate. Ultimately, you are responsible for any outstanding balances. Payment of your insurance deductible, co-payment, and/or coinsurance is due and collected on the date of service.

REFUNDS AND EXCHANGES: All sales are final and there will be no refunds or exchanges on professional services, contact lenses, or glasses. If using your insurance, your insurance will be filed at the time of purchase. Once insurance is filed and benefits are used, Premier Eye Associates is not responsible for contacting any insurance to reverse the filing.

HIPPA: PRIVACY POLICIES & PRACTICES

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

- **Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.
- **Payment:** We may use and disclose your health information to obtain payment for services we provide to you.
- **Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.
- **Insurance:** You authorize Premier Eye Associates to release medical information about you to your insurance providers to determine benefits or the benefits payable for related services.
- **Your Authorization:** In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.
- **Required by Law:** We may use or disclose your health information when we are required to do so by law or national security activities.
- **Abuse or Neglect:** We may disclose your health information to appropriate authorities when we suspect abuse or neglect.
- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

ACKNOWLEDGEMENT

I have read, understand, and agree to the previously stated policies and practices of Premier Eye Associates.

Patient Signature (Guardian if under 18)

Date

Premier Easy Pay

Premier Easy Pay provides you the convenience of saving a card on file to pay any outstanding balances rather than having to mail us a check! We run all our payments through our HIPAA-compliant, secure practice management software. Office personnel will not have access to your card information. For your protection, only the last 4 digits of your card will show in our system. Not only does Easy Pay save you time, but it helps you avoid any late payment fees!

AFTER YOUR INSURANCE PROCESSES: IF YOU OWE A BALANCE

- **BALANCE \$50.00 OR LESS**
 - Credit card on file is automatically billed.

- **BALANCE OVER \$50.00**
 - Statement sent - payment due within 14-days
 - Payments not received after 14-days, card on file billed

- **LATE PAYEMENTS**
 - 10% late fee added per month
 - Collections after 60 days. Patient assumes 33% collection fees

Other Patients Card is Approved For	Relationship

Please check one option below

<input type="checkbox"/>	I would like to enroll in Easy Pay and have my card on file automatically charged for any outstanding balances.
<input type="checkbox"/>	I do not want to enroll in Easy Pay. I prefer to mail a check.

Cardholder Signature
Date
Cardholder Email

Credit Card Last 4

=====STAFF ONLY=====

<input type="checkbox"/>	Form scanned into Crystal
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Premier Easy Pay

If you would like to enroll in easy pay, please enter your card information below. This form will be shredded and will not be stored on file.

To Be Shredded

Account Type: <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard <input type="checkbox"/> America Express <input type="checkbox"/> Discover
Cardholder Name: _____
Credit Card Number: _____
Expiration Date: _____
Security/CVV: _____