Moretsky Cassidy LASIK

VALLEY EYE SPECIALISTS, P.L.C.

Sanford L. Moretsky, D.O., P.C.
Craig R. Cassidy, D.O., P.C.
Gerald J. Hobson, M.D.
Richard J. Kalina, O.D.

Patient Information and Release

DATE: _____

Name: _____ (First) _____ (Middle) _____ (Last)

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

DOB: ___/___/___ **Age:** _____ **Sex:** ☐ M ☐ F **SS#:** ___/___/___

Spouse's Name: _____ ☑ Married ☐ Divorced ☐ Single

Home Phone: ( ) _____ - _____ **Cell Phone:** ( ) _____ - _____

Your Employer: _____ **Address:** _____ **Work Phone:** ( ) _____ - _____

Occupation: _____ **Email:** _____

① **Primary Care Doctor (PCP):** _____ ② **Referring Doctor or Optometrist:** _____

Address: _____ **Address:** _____

_____ _____

Phone: _____ **Phone:** _____

① **Primary Insurance Company:** _____ **Member ID #:** _____ **Group #:** _____

Address: _____ **Policyholder's Name:** _____

_____ **Policyholder's DOB:** ___/___/___ **Relationship:** _____

② **Secondary Insurance Company:** _____ **Member ID #:** _____ **Group #:** _____

Address: _____ **Policyholder's Name:** _____

_____ **Policyholder's DOB:** ___/___/___ **Relationship:** _____

③ **Pharmacy Name:** _____ **Phone #:** _____

Address: _____

_____

REFRACTION CHARGE: An eye exam consists of two separate parts: The medical evaluation and the refraction (a prescription for glasses).

Medicare and medical insurance do not cover refraction services for eyeglass prescriptions. **A forty-five dollar ($45) fee will be collected at time of service. We do not bill your insurance for this service.**

☐ **Yes – I want the refraction.** ☐ **No – I do not want the refraction** **Initial:** _____

NOTICE TO PATIENT: We are not equipped to lift/move non-weight bearing patients. If you are unable to move from your wheelchair to the exam chair, you must bring your own caregiver to assist you, or we will be unable to provide services. We apologize for any inconvenience this may cause.

NOTICE OF PRIVACY PRACTICES: I understand that **Valley Eye Specialists, P.L.C.** and/or **Valley Outpatient Surgical Center, Inc.**, in compliance with HIPAA regulations, has published a "Notice of Privacy Practices," and that I have received and/or have a right to receive said notice.

AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby authorize Medicare and/or insurance company, medical service company, worker's compensation carrier, welfare fund, or employer to make payment directly to **Valley Eye Specialists, P.L.C.** and/or **Valley Outpatient Surgical Center, Inc.**, the medical benefits herein specified and otherwise payable to me but not to exceed the regular charges for this treatment. I understand I am financially responsible for any services not covered.

AUTHORIZATION TO SUBMIT CLAIMS: I hereby authorize **Valley Eye Specialists, P.L.C.** and/or **Valley Outpatient Surgical Center, Inc.** to submit claims to Medicare and/or my insurance company, medical service company, worker's compensation carrier, welfare fund, or employer on my behalf.

RELEASE OF INFORMATION: I hereby authorize the release of that part of my record which is required to submit a claim to and collect payment from Medicare, insurance companies, worker's compensation carriers, welfare funds, and employers for services rendered.

FINANCIAL AGREEMENT: The undersigned agrees, whether he/she signs, as agent or patient, that in consideration of the services to the patient, he/she hereby individually obligates himself/herself to pay the account to **Valley Eye Specialists, P.L.C.** and/or **Valley Outpatient Surgical Center, Inc.** in accordance with the regular rates and terms.

Our office reserves the right to charge a collection fee and/or charge for NSF checks. We request that your **office visit be paid at the time** service is rendered, unless other previous arrangements have been made.

INSURED PATIENTS:

A. Medicare patients are responsible for 100% deductible and 20% co-payment, and any non-covered services. Payments of 20% of the Medicare allowable will be expected at the time of service, unless we are contracted with a Medigap insurance.
Initial: _____

B. Patients with Medicare replacement plan, HMO, PPO, and indemnity plans that we are contracted with will be expected to pay their co-pay at the time of services. All patients will be responsible for deductibles, co-pay, and non-covered services.
Initial: _____

C. Proper Referrals and Authorizations are required by your plan and must be received prior to service. If you do not provide correct information for billing, you will be responsible for payment in full for service rendered. **Initial:** _____

D. If we are contracted with your insurance carrier, we will submit a claim to your insurance. If we are not contracted, it is the patient's responsibility to submit the claim. **Initial:** _____

Valley Eye Specialists P.L.C., and/or Valley Outpatient Surgical Center, Inc., Dr. Moretsky and Dr. Cassidy cannot guarantee reimbursement from your insurer for the medical services rendered on your behalf. The client/insurer relationship is separate and independent from the patient/physician relationship. Nonetheless, we will be happy to answer your questions and assist you whenever possible.

PRIVATE PAY PATIENTS:

Payment is required at the time of service, unless other arrangements have been made. **Initial:** _____

BY SIGNING BELOW, I ACKNOWLEDGE THAT THE INFORMATION THAT HAS BEEN PROVIDED IS ACCURATE, AND THAT I HAVE READ AND UNDERSTAND THE PATIENT INFORMATION AND RELEASE POLICY.

_____ _____
Signature: Patient, Parent, Guardian, or Representative **Date**

_____ _____
Signature: Witness **Date**