Family EyeCare, Dr. Nazia Maredia, O.D.

INSURANCE INFORMATION/GUARDIAN

Medical Insurance Name (write below)	Patient ID # / Group #
______________________________	______________________________
Primary cardholder's name (if different from above)	Primary cardholder's DOB
______________________________	______________________________
Primary cardholder's Social Security Number	Primary cardholder's relationship to the patient
______________________________	______________________________
Primary cardholder's address (if different from above)	Primary cardholder's employer
______________________________	______________________________
Vision Insurance Name and ID number	Patient Name and DOB
______________________________	______________________________

Some conditions default coverage from routine vision to medical office visit and/or insurance. I understand that fees may vary based upon presentation, symptoms, and diagnosis of the office visit. ________________________ (Patient or Guardian's initials)

INFORMED CONSENT & TREATMENT AUTHORIZATION

- I (do) ___ (do not) ___ authorize Nazia Maredia, O.D., and/or his staff to leave a message with available persons at my home phone number, on my answering machine or with the emergency contact listed above.
- I (do) ___ (do not) ___ authorize Nazia Maredia, O.D., and/or his staff to leave a message at my work.
- I (have) ___ (have not) ___ been provided a copy of the Privacy Practices of Nazia Maredia, O.D.

I hereby authorize Nazia Maredia, O.D., to provide a diagnosis and optometric treatment to my child or me. I further authorize the release of Protected Health Information to additional physicians or optometrists in order to facilitate continuity of care.

X ____

Patient or Legal Guardian's Signature   Relationship   Date

OUR FINANCIAL & INSURANCE FILING POLICY

- All charges are your responsibility, whether or not your insurance company pays. Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We cannot become involved in disputes between you and your insurer regarding covered charges, deductibles, or co-pays.
- If your insurance company does not pay your claim within 45 days, it is your responsibility to contact them to expedite payment. If your insurance company refuses to pay, **you are responsible for payment.**
- Payment for co-pay and/or deductible is due at the time services are rendered.
- We accept Cash, Visa, MasterCard and Discover. We do not accept checks.
- Refraction is not covered by your Medicare and some other insurance; therefore you will be charged a fee in addition to your co-pay and/or deductible.

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION AND ASSIGNMENT OF BENEFITS

I , ____authorize the release of all necessary Protected Health Information and assign all medical and vision benefits to Nazia Maredia, O.D., I also request that payment of authorized Medicare (if applicable) benefits be made on my behalf to Nazia Maredia, O.D., for any services furnished to me by Nazia Maredia, O.D. I authorize any holder of medical information related to me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents, any information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 12 of the CMS 1500 claim form is completed, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-pay, and non-covered services. Copay and deductible are based upon the charge determination of the Medicare carrier. I understand that I am ultimately responsible for any bill incurred in this office. Should this account become delinquent, I will be responsible for any and all legal fees, court costs, and collection charges. There will be a service charge for each returned check. This authorization and assignment will remain in effect until revoked by me in writing. A photocopy of this authorization and assignment is to be considered as valid as the original. I request that you file my insurance and I have agreed to and completed all of the conditions listed above. I accept financial responsibility for all charges. I have read and understood this information and I am signing voluntarily.

X ____

Patient or Legal Guardian's Signature   Relationship   Date