PATIENT REGISTRATION

Date _____/_____/_____ SSN ______________________ Date of Birth _____/_____/_____ Age ___________

Patient's full name ____
first middle last

Home address ____
street city state zip

Parents full names if patient is a minor ____

Home phone (____) ____________________ Work phone (____) ____________________ Cell phone (____)_______________

Insured name: ____ Insured SS# _____________________________

Insurance Company: Vision Plan ______________________________ Major Medical _____________________________

Relationship to insured: self/spouse/child/other

Method of payment: ______ Check/Cash _______ Insurance ______ Credit Card _______ Medicare

OFFICE POLICY

In order to maintain our economical professional fees and material charges, we must adopt the following office policy.

A. When only PROFESSIONAL FEES are incurred, payment is expected at the time of service.
B. When PROFESSIONAL FEES and MATERIAL CHARGES are incurred, total payment is required before materials can be ordered.
C. When only MATERIAL CHARGES are incurred (glasses or contacts) full payment is required before the order can be placed.
D. We cannot be responsible for delays due to lab breakage and or manufacturer back order. Please note: we have no control over delays/ loss of items via the United States Postal Service, United Parcel Service or other carrier organizations.
E. Glasses orders cancelled during lab processing may incur a handling cost up to 50% of the charge amount.
F. Any dissatisfaction with the lenses/frames must be brought to our attention within 30 days of dispensing/delivery for valid/appropriate assessment.
G. In the unlikely event that your visual system cannot tolerate certain styles of multifocals:
PROGRESSIVE LENSES: can be substituted with a pair of conventional trifocals OR conventional bifocals at no additional charge.
TRIFOCAL LENSES: can be substituted with a pair of conventional bifocals at no additional charge.
BIFOCAL LENSES: can be substituted with a pair of single vision distance or near lenses.
PLEASE NOTE: NO REFUNDS WILL BE MADE ON THE DIFFERENCE BETWEEN MULTIFOCAL STYLE CHARGES.
LENS SUBSTITUTIONS ARE FOR COMPARABLE TINTS, COATINGS, ETC.
H. Written contact lens prescriptions are obtainable only after completion of the initial fitting period for new fits. Established contact lens wearers may receive an updated prescription only after a contact lens check-up has been provided. **A separate, additional fee is charged for the check-up.**
I. When using old frames for prescription lenses, neither we nor our optical laboratory can accept responsibility for frame damage in the process of handling.
J. Frames/spectacle lenses lose their ability to withstand the pressures of adjustment/repair with time. While we use the utmost care, WE CANNOT BE RESPONSIBLE FOR ANY DAMAGES INCURRED DURING THE PROCESS.
K. Scratch resistant lens coatings are just that, RESISTANT, not scratch proof.
L. **PAST DUE ACCOUNTS will be assessed a $5.00 rebilling charge after 10 days and $10.00 the next 10 days.**
M. **RETURNED CHECKS are subject to a $30.00 returned check fee.**
N. **Past due accounts sent to collections will triple the amount originally owed.**
O. This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.
P. Any cancelled orders paid by credit card will be subject to a service charge of 10% of the total amount charged.

REFERRAL ACKNOWLEDGMENT

A referral for further evaluation/treatment may be made when a potential problem exists that could have significant consequences if not appropriately addressed. Some consequences can lead to blindness or be a threat to your life. While we use the utmost care, we cannot absolutely guarantee that all referral letters, phone calls or faxes are received. We make the referral in good faith and with your acknowledgment. In order to safeguard your well being, it is incumbent upon you to contact us if you have not obtained your referral appointment in a timely fashion. The ultimate decision/responsibility to keep the appointment is always yours.

RETURN VISIT ACKNOWLEDGMENT

A return visit to our office to further evaluate/treat a present condition is made in good faith. Without further evaluation/treatment some conditions may have consequences that could lead to blindness or be a threat to your life. When appointments made for further evaluation/treatment are not kept the responsibility for the condition becomes yours.

EYEWEAR SAFETY DISCLOSURE

Whether for dress or safety eyewear you have a choice between glass or plastic lens materials. From strictly a protective basis (i.e. foreign body penetration through the lens material), the type of material that provides the greatest benefit is that of polycarbonate plastic lenses. Preventing an injury is something we should all aspire to attain. However, it is not just a function of simply wearing polycarbonate lenses. Should you have any situations where you feel at an increased risk of sustaining an eye injury, please let us know. In any event, the ultimate decision to go with polycarbonate lenses for its protective benefit is always yours.

FINANCIAL RESPONSIBILITY

Insurance is billed, in most cases, as a courtesy to the patient by Dr. Miller's office. The undersigned authorizes direct payment to Dr. Miller, with any insurance benefits otherwise payable to the undersigned, for Dr. Miller's services. It is understood by the undersigned that he/she is financially responsible for charges not covered by the payment that Dr. Miller receives from the insurance company. Verification for eligibility is not a guarantee of payment.

EMERGENCY CONTACT

Please provide us with the name and phone number of two people we can contact for you in case of an emergency.

Name ______________________________ Phone# (   ) ____________________

Name ______________________________ Phone# (   ) ____________________

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical or other information necessary to process this transaction. I also authorize my insurance benefits to be paid directly to Dr. Miller. I understand that if in the event my insurance carrier pays less than the actual bill for my services, I agree to be responsible for payment of all services and/or materials rendered on my behalf or my dependents. I have read and understand the content of these two pages.

______________________________ ____________________ ____________

Signature of patient (or parent/guardian if a minor) (relationship) Date