Joliet EyeCare Associates Dr. Tahir & Staff www.JolietEyeCare.com

Thank You for Choosing Us and Welcome

About You – The Patient

Date:___/___/_____

Last:_____

First:_____ MI: _____

Birthday: _____/_____/_____ **Sex:** ☐M ☐F

Social Security #: _____-_____-_____

☐Single ☐Married ☐Other

Address:_____

City:_____ State: _____ Zip: _____

Driver Lic. # _____

Employed: ☐Full ☐Part ☐Retired ☐Student

Employer Name: _____

Person Responsible for this account

☐Same ☐Mom ☐Dad ☐Legal Guardian

Last:_____

First:_____ MI: _____

Birthday: _____/_____/_____ **Sex:** ☐M ☐F

Social Security #: _____-_____-_____

☐Single ☐Married ☐Other

Address:_____

City:_____ State: _____ Zip: _____

Driver Lic. # _____

Employed: ☐Full ☐Part ☐Retired ☐Student

Employer Name: _____

Ways to Contact You - Responsible Party for the Account

Home # ( ) _____ Cell # ( ) _____

Work # ( )_____ Preferred method: ☐Cell ☐Home ☐Work

Email Address- Appt. Reminders, Office Info, Sales

Please Print Clearly

Used only by our office for recalls, appt. confirmations, glasses-contact lens, etc.

Your Doctors - List if You Have Any

Primary Physician: _____ Location: _____

Diabetic Doctor: _____ Location: _____

RA Doctor/Other: _____ Location: _____

A Few Questions

How did you hear about us /who may we thank: _____

Can we leave test results, office info, appointment info., etc. on your answering / voice mail: ☐Yes ☐No

Can we leave information with another family member: ☐Yes ☐No - if yes, who: _____

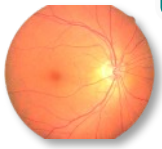
Reason for visit: ☐Eyeglasses ☐Contact Lenses (fitting fee applies) ☐ER ☐Other: _____

In case of Emergency who should we contact

Name: _____ Home ( ) _____ Cell ( ) _____

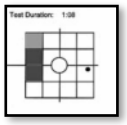
PREVENTION WITH MEDICAL SCREENING

TESTS RECOMMENDED - VISION SCREENING IS NOT ENOUGH



- **DIGITAL SCANNING OF THE RETINA**
  Diabetes, bleeds, detachments, blood pressure, glaucoma, retina changes, cysts, etc.

- **CENTER VISION RISK - MACULAR DEGENERATION**
  Center/color vision loss from UV damage, family history, smoking, poor nutrition, etc.



- **SIDE VISION LOSS RISK**
  Loss of vision, strokes, glaucoma, retinal detachment, center vision loss, etc.

Adults 18 and Older	17 and Younder
$65 for ALL Three Tests (Saving of 25%)	$45 for Two Tests (Saving of 20%)
☐Yes ☐No	☐Yes ☐No

FREQUENTLY ASKED QUESTIONS

- **ARE THEY COVERED BY MY INSURANCE?**
  Preventative tests are not covered by your insurance.
- **ANY PAIN- HOW LONG?**
  No pain, 3-5 min done today.
- **I JUST HAD A PHYSICAL AND DON'T HAVE ANYTHING WRONG.**
  Physicals and blood work cannot check for many eye diseases which cause blindness, we can.

DILATION

Included with today's exam (4-6 hrs. blurry vision especially up close)

☐Yes Dilation today (*new patient within 30 days at no cost).

☐No I assume all risks in eye diseases including blindness. I may reschedule for $35.00.

** All New Patients are required to have a dilation within 30-days without our office.*

OFFICE POLICY - PAYMENT - INSURANCE

- A credit card on file or deposit is required to bill any medical claim to your medical insurance.
- I am fully responsible for all charges/co-pays today for myself and family. I give authorization to submit claim(s) and release required information to my insurance company(s), its intermediaries, attorneys, or another physician's office as deemed necessary. I request the insurance carrier, commercial, private or governmental to pay directly to Joliet EyeCare Associates the amount due for services rendered.
- Insurance(s) must be present before any visit (vision,medical or workman's comp). Joliet EyeCare Associates does not reverse bill, after the fact, for any reason, to any insurance company.
- All remaining balances including: co-pays, co-insurances, deductibles, denials and any non-covered service as deemed by my insurance(s) are your responsibility. Most insurances do not cover a refraction, screening/preventative care, and some speciality tests, which are all out of pocket expenses.
- I have reviewed a copy of the HIPPA privacy act law. A hard copy to take home is available on request.
- Dilation and other testing are covered today pending insurance. Postponed testing incurs a $35 charge and completion of test(s) must be done within 30-days.
- Payment Fees:
  - If sent to collections 33% above total fee and all other collection fees (attorney, courts, etc) will be charged.
  - NSF checks: $25 service fee plus money owed.
  - Late fees 6% to balance owed monthly.

CANCELLATION POLICY OF GLASSES - CONTACTS - NON PICKED UP ITEMS

- Problems? Changes/rechecks on glasses, contacts, etc. must be presented within 60 days of your exam or additional charges will apply.
- Product must be picked up within 90-days of notification (glasses, contact, or other items). Unclaimed items will be given to charities and no refund or credit will be issued regardless of reason. Any remaining balance on account will be owed or charged to your credit card on file.
- Eyeglass lenses (and/or contacts) are custom made for you and your prescription in a frame you choose. We can remake your lenses one time before 60-days, on many occasions, if a problem arises. If a return is required, regardless of insurance, a 15% restocking fee is assessed and store credit is given. No returns will be accepted after 60-days. There is never a refund on any services performed.

Payment is due today regarding your co-pays, tests and/or any other charges

Signature: _____

Responsible for Account: _____ Date:_____/_____/_____

Signature ensures you have read and agree to terms on all pages

Dr. Tahir & Staff
www.JolietEyeCare.com
815-744-3222

- Credit Card Policy -

REQUIRED FOR MEDICAL CARE - RECOMMENDED FOR VISION

AFTER YOUR INSURANCE PROCESSES:

$25.00 OR LESS BALANCE

- Balances of $25.00 or less, CC on file will automatically be billed.

OVER $25.00

- Statement sent and payment will be due within 14-days (ex. cash, check, online, etc).
- Payments not received after 14-days, card on field will be charged full amount.

OTHER:

- 6% late fee assessed after 14 days and monthly.
- Collections after 90 days. Patient assumes all collection fees.
- If a refund is owed, it will be placed on your card within 3-days.

CREDIT CARD TYPE: VISA MasterCard Discover Care Credit

CC Number: XXXX-XXXX-XXXX- ☐☐☐☐ **EXP. DATE:** _____/_____

PLEASE HAND YOUR CARD UP-FRONT AFTER COMPLETING THIS FORM

This Card is Also Approved For Other Patient(s) Below:

NAME	Relationship
1)	
2)	
3)	
4)	

I understand- I am responsible for <u>all remaining balances including</u>: co-pays, co-insurances, deductibles, denials and any non-covered service as deemed by my insurance(s) or office policy. Remaining balance of $25.00 or less will automatically be billed to my credit card and a receipt can be requested. I authorization Joliet Eyecare Associates to keep this information on file and charge my card for payment and refund purposes only.

_____ Signature of Card Holder

_____ / _____ / _____ Date