**WELCOME FORM**

**MACQUEEN EYE CARE CENTER, LTD**

Print Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPPA INFORMATION**

I was offered a copy of MacQueen Eye Care’s Notice of Privacy Practices. \_\_\_\_YES \_\_\_\_\_NO

Authorized Person Print Name(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL POLICY**

Thank you for choosing MacQueen Eye Care Center as your eye care provider. We are pleased to provide you with the best eye care services possible. The following information explains our financial policy. Please read and sign that you understand the policy.

1. The patient portion/copays and non-covered services are due at the time services are rendered unless other arrangements are made in advance. All professional services and materials are charged to the patient.
2. Payment from my insurance company is to be paid directly to MacQueen Eye Care Center. I understand that the primary Vision or the primary Medical insurers listed in my file will be billed as my primary insurance.
3. All benefits quoted to me are not a guarantee of payment by my insurance company.
4. If the patient does not have insurance, or proof of insurance (Insurance card), payment in full is due at the time of service.
5. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance.
6. Accounts that are ninety (90) days old may be subject to a collection fee of **$35.00.**
7. There will be a **$35.00** service charge on all returned checks.

**\*Please note relating to refraction:**

Refraction is the process of determining if there is a need for corrective eyeglasses. It is necessary to write a prescription for glasses or contact lenses. Most medical insurance plans, including Medicare, do **NOT** cover routine refractions or routine eye examinations (when no medical eye problem is known or suspected). Your vision plan may assist you with your eye care needs that are not covered by your medical plan. Please notify us if you have any vision coverage. Our office fee for refraction is **$45.00** and is collected at the time of service along with any additional copayments due.

**EMAIL/TEXT CONSENT**

We may make use of email and text messaging to communicate with our patients, including the patient portal.

\_\_\_\_ Patient acknowledgement; I understand that my email address and cell phone number will be used for the sole purpose of information delivery or receipt with MacQueen Eye Care Center. MacQueen Eye Care Center may email and/or text me appointment reminders and material notifications. I wish to provide my email for access to the patient portal.

\_\_\_\_ I decline, and do not wish to provide my email for communication and/or the patient portal access.

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDITIONAL INFORMATION**

The American Recovery and Reinvestment Act of 2009 require providers to request the following. Please feel free to choose “Decline to Answer” if you are not comfortable supplying the information.

1. I am (Race)… 2. I am (Ethnicity)…… 3. My preferred language is..

\_\_\_ American Indian or Alaska native \_\_\_ Hispanic or Latino \_\_\_ English

\_\_\_Asian \_\_\_Not Hispanic or Latino \_\_\_Spanish

\_\_\_Black or African American \_\_\_Decline to Answer \_\_\_ Other

\_\_\_White \_\_\_Decline to Answer

\_\_\_Hispanic

\_\_\_Decline to Answer

**SIGNATURE REQUIRED**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to MacQueen Eye Care Center. I understand that I am financially responsible for any balance. I also authorize MacQueen Eye Care Center or insurance company to release any information required to process my claims.

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Patient/Guardian Signature