TREASURE VALLEY | EYE CENTER

Notice of Practice Policies

Welcome to our office!

Thank you for choosing our office for your eye care services. Please take time to complete our paperwork accurately and completely. This information is held in complete confidence as part of your permanent record. Please see our Notice of Privacy Practices for more information on medical information use and disclosure.

Insurance Information

If you would like us to bill your insurance, we must have your most current insurance information prior to services being provided. Please provide medical and vision insurance cards at check-in in addition to policy holder information via registration form.
As a specialty clinic we may be billing your medical insurance. Please keep this in mind as you check in.

Financial Policy

We will gladly bill your insurance company for your appointment, however, this is NOT a guarantee of payment. Please remember that in some cases it can take 6-8 weeks for a response from your insurance company. Our billing department will work diligently on your behalf.
Co-payments, deductibles and non-covered service balances are due at the time of service. After your insurance has processed your claim, you may be sent a statement for any additional out-of-pocket expenses determined after your insurance has processed your claim.
For your convenience, we accept cash, check, all major credit cards and Care Credit.
Accounts not paid after 90 days will be assessed a $20.00 late fee. All balances must be paid in-full before 120 days. Balances 120 days overdue will be turned over to collections.

Important Payment Information Regarding Refractions

Refraction is the process of determining the eye's refractive error, or need for glasses and/or contact lenses. It is an essential part of an eye examination, but is considered a **non-covered** service by **Medicare** and many other private insurance companies; thus, it becomes the responsibility of the patient to pay for the refraction portion of the examination. Our office fee for a refraction is **$59.00**.

Cancellation/No Show Policy

We require a 72 hour notice for appointment cancellations. Appointments not cancelled within 72 hours will be subject to a $50 service charge as will confirmed appointments you do not show for. We do understand there will be emergent circumstances and will work with our patients in these situations.

Updated 03/31/22

I acknowledge that I have received a copy of Treasure Valley Eye Center's Notice of Practice Policies.

I authorize the release of any medical or other information necessary to process any claims arising from services and materials provided. I also request payment of government or private insurance benefits to the physician accepting assignment for the services and materials provided. I also understand that I assume all financial responsibility for this account and all amounts due regardless of insurance coverage.

______________________________	______________________________
Patient's printed name	Relationship to patient
______________________________	______________________________
Date	Signature

Patient Registration

Treasure Valley Eye Center

Welcome to our practice. In order to better serve you, please completely fill out the following information. Dr. Miller, Dr. Williams, and Dr. Christensen thank you for allowing us to serve you.

Last Name______________________ First Name______________________ Middle Init____________

Name you prefer to be called______________ Date of Birth______________ Social Security #________________

Address______________________________ City______________ State__________ Zip__________

Home Phone________________ Daytime Phone________________ Cell Phone________________

Employment Status: Full-Time Part-Time Student Retired
(please circle one)
Employer:______________________
Occupation:______________________
Marital Status: Single Married Divorced Widowed
(please circle one)
Email Address______________________

Financially Responsible Party Name______________________ Date of Birth______________
(if different from above)
Social Security #______________

Address______________________ City______________ State__________ Zip__________

Phone________________ Relationship to Patient______________________

Family members you would like financially linked to your account:
Name________________ Date of Birth__________ Name________________ Date of Birth__________

Emergency Contact (friend or family not living with patient): Name______________________
Phone______________________ Relationship to Patient______________________

Medical Insurance	Primary Medical Insurance Company:______________________ ID #________________ Group #________________ Policy Holder Name:________________ Policy Holder Date of Birth:________________ Secondary Medical Insurance Company:______________________ ID#________________ Group #________________ Policy Holder Name:________________ Policy Holder Date of Birth:________________
Vision Insurance	Do you have a supplemental Vision Plan as part of your insurance policy OR a SEPARATE Vision-ONLY Policy? Yes____ No____ Don't Know____ VSP______ EyeMed______ Other:________________ Policy Holder Name:________________ Date of Birth:__________ Social Security #__________

Please provide us with the above information and a copy of your cards in order for us to process medical and vision claims more efficiently.

Lifestyle & your vision: What activities/hobbies are important to you or in which you spend much of your time?

- ☐ Reading
- ☐ Computer work
- ☐ Driving
- ☐ School work
- ☐ Sports - which ones?________________
- ☐ Outdoor Activities – which ones?________________
- ☐ Hobbies – which ones?________________
- ☐ Other – specify________________

How did you hear about us? (please check all that apply)

- ☐ Referred by another doctor? Who?________________
- ☐ Insurance Company Provider List
- ☐ Referred by a friend or family member? Who?________________
- ☐ Website or Internet Search
- ☐ Other – specify________________

I, the undersigned, certify that I (or my dependent) have the above insurance benefits and assign directly to Treasure Valley Eye Center all insurance benefits payable to me for the services rendered. I understand that I am financially responsible for all charges whether paid for or not by insurance. I hereby authorize Treasure Valley Eye Center to release all information necessary about diagnoses and services rendered to secure the payment of benefits and authorize the use of this signature on all insurance submissions.

______________________________ Signature

______________ Date

NAME______________________________ DOB______________________________

REFERRING DOCTOR______________________________ PRIMARY DOCTOR______________________________

Social History

☐ Smoke_____pk/day

☐ Drink _____day/week/month

☐ Occupation

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☐ Married ☐ Single ☐ Divorced ☐ Widowed

Do you live alone? ☐ Yes ☐ No

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Family History

☐ Macular Degeneration

☐ Glaucoma

☐ Retinal Detachment

☐ High Blood Pressure

☐ Heart Disease

☐ Diabetes

☐ Other ______________________________

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MEDICATIONS

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ALLERGIES

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Review of Systems

Constitutional

☐ Weight gain/loss

☐ Chronic fatigue

☐ Fever/chills

Musculoskeletal

☐ Painful joints

☐ Rheumatoid arthritis

☐ Swollen joints

Urinary

☐ Painful urination

☐ Incontinence

☐ Difficult urination

Neurological

☐ Numbness/weakness

☐ Loss of memory

☐ Dizziness

☐ Slurred speech

☐ Headache

Gastrointestinal

☐ Nausea

☐ Vomiting

☐ Constipation

☐ Diarrhea

☐ Abdominal pain

Respiratory

☐ Shortness of breath

☐ Wheezing

☐ Cough

☐ Asthma

☐ Lung disease

Ear/Nose/Throat

☐ Loss of hearing

☐ Sinus problems

☐ Swollen glands

☐ Nose bleeds

Heart/Circulation

☐ Chest pain

☐ Irregular heart beat

☐ Sleep with extra pillows

☐ Extremity swelling

Integumentary

☐ Rashes

☐ Lumps in breast

Hematological

☐ Easy bruising

☐ Anemia

☐ Low blood count

Endocrine

☐ Hormone therapy

☐ Excessive thirst

☐ Frequent urination

Allergy/Immunology

☐ Hay fever

☐ Environmental allergies

Past Medical History

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Eye Diagnosis/Surgeries/Injuries

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EYES

☐ Blurry Vision

☐ Flashing Lights

☐ Floaters

☐ Double Vision

☐ Watering

☐ Itching

☐ Burning

☐ Glare

☐ Red Eye

☐ Eye Pain

☐ Dry Eye

TREASURE VALLEY | EYE CENTER

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

Treasure Valley Eye Center's Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you.

I acknowledge that I have received the Notice of Privacy Practices and understand that I should read it carefully. I may obtain copies of the Notice of Privacy Practices by calling Treasure Valley Eye Center at 208-288-2020 to by visiting www.treasurevalleyeye.com

______________________________________ _______________________

Signature of Patient or Patient's Representative Date

______________________________________ _______________________

Print Name Relationship to Patient

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Interpreter (if applicable)

Please provide us with the name or names of person/people to whom we may disclose confidential information (other than spouse):

Name:__________________________ Relationship:__________________ Phone:___________

Name:__________________________ Relationship:__________________ Phone:___________