Vision PLUS: RETURNING PATIENT UPDATES

Patient Updated Information

WELCOME BACK! WE APPRECIATE HAVING OUR FORMER PATIENTS RETURN FOR THEIR EYE HEALTH CARE NEEDS!

PLEASE PROVIDE US WITH ANY UPDATED INFORMATION. THANK YOU!

Today's Date_____

Last Name_____

First Name_____

Address Change? __ No __Yes (Provide Info)

Street _____

City _____ State ___

Zip Code _____

Phone Number Change? __No __Yes (Provide Info)

Home Phone _____/_____/_____

Work Phone _____/_____/_____

Cell Phone _____/_____/_____

E-MAIL INFORMATION

Vision PLUS welcomes the opportunity to send you valuable information, i.e., newsletters, birthday greetings, upcoming appointments, when your eyewear is ready for pick-up via your E-mail address. Also, with the use of your E-mail address, you now have the opportunity to request a time for your next eye health examination. While it is strictly confidential, it is also your option to share your E-mail with us. Please be sure to write clearly.

EMAIL _____

(Your E-mail information is held with strict confidentiality. It will not be shared with any outside persons or sources.)

VISION BENEFIT PLAN/MEDICAL INSURANCE

Insurance Change? ___No ___Yes (Provide Info & New Insurance Card)

Vision Benefit Plan:

_____

Medical Insurance:

_____

Our Mission at Vision PLUS is to provide our patients with the upmost quality care using state-of-the-art equipment, technology, and continuing education!

We take great pride in our patients!

"TRUST THE HEALTH OF YOUR EYES TO US VISION PLUS"

PATIENT GUIDELINES
FINANCIAL ASSIGNMENT (Signature Required Covers Entire Document)

-I understand that if during the course of my examination the doctor determines the need for medical testing & treatment, even though my insurance form states well vision, it will be filed to my medical insurance vice filed as a well visit and I will pay all co-pays, etc.

-I understand that I am financially responsible for all fees, and agree to reimburse any and all fees for services and materials not collected in full should my medical insurance or vision plan deny payment for services or materials rendered.

-I further understand that I agree to pay for any unpaid balances on my account as a result of denial in part or whole from my insurance carrier caused by denial of medical services, unmet deductibles, non-covered services i.e., refractions, or uncollected fees for prior services.

-If I do not inform you that I have a vision plan or medical insurance before services are rendered, it will be assumed that no coverage exists and I am responsible for all payments.

-I agree this office, NO EXCEPTIONS, will not back file claims or refund fees after services are rendered due to lack of notification of vision or medical insurance. It will be my responsibility to file my own claim and seek reimbursement from my insurance carrier.

-If I fail to reimburse said fees in a timely manner to Vision PLUS, and should the need arise, I agree to pay any and all collection fees, court costs, and attorney fees.

_____ ____/_____/_____

Patient or Guardian /Signature Date

_____

Relationship to Patient

OFFICE POLICY

CONTACT LENSES: Due to the expense involved in contact lenses, i.e., Rigid Gas Permeable (RGP), Soft Torics, Specialty Contact Lenses, a fifty (50) percent deposit is due for the following: 1.) the patient is being prescribed the lenses* on a trial basis, 2.) the patient is placing an order for the contact lenses.

*If a patient is having difficulty and cannot wear the trial lenses, the patient will either receive a full refund, or apply the deposit to another lens.

DEPOSITS: Deposits are forfeited after thirty (30) days unless there is a valid reason.
WARRANTY: Insurance warranty one time replacement on all frames/lenses is good for one (1) year. **NO INSURANCE WARRANTY**: Frames/lenses, one time replacement, are good for (2) two years.
RETURN ON FRAMES OR LENSES: There is a thirty (30) day return policy.
RESTOCKING FEE: A charge due **o**n refunds/returns deemed a specialty product.