Patient Information

Name: _____ Occupation: _____

Gender: ☐ Male ☐ Female _____ Today's Date: _____

Address: _____ Home/Cell Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Birth Date: _____-_____-_____ Height: _____ Weight _____ Email: _____

Race _____ Ethnicity _____ Preferred Language _____ Communication Preference _____

Guardian (if Applicable): _____ Last Eye Exam: _____

Name of Primary Care Physician: _____ Last Medical Exam: _____

Vision Insurance

Insured's Name: _____ Birth Date: _____-_____ - _____ Relationship: _____

Insured's Employer's Name: _____ Insurance Provider: _____

Insured's Member ID Number: _____ Insured's Group Number: _____

Primary Medical Insurance OR Secondary / Supplement for Medicare Only

Must present ID card and scan into system

Insured's Name: _____ Birth Date: _____-_____ - _____ Relationship: _____

Insured's Employer's Name: _____ Insurance Provider: _____

Insured's Member ID Number: _____ Insured's Group Number: _____

HIPAA Notice and Acknowledgment

Acknowledgment: I acknowledge I have received and read the Notice of Privacy Practices. Yes ❑ No ❑

Patient Notification– Consent to Treatment

Please be advised that if you are being seen today for a Routine Eye Exam that based upon any or a combination of the following concerns: family history, current medical disease and/or conditions, chief complaint, pre-test findings the Doctor may find it necessary to bill your exam medically as well as order additional tests. You will be notified during the course of the exam by the Doctor if medical billing is necessary. **Exams billed medically are not covered under your Routine Eye Exam benefits or Vision Insurance Plan. If a medical issue exist, your exam will be billed medically through your Medical Insurance Carrier and are subject to their specific copays, deductibles, and co-insurance which will be due at the time of service.** In the event you want a routine examination for your eyeglass or contact lens prescription, I understand it is my responsibility to immediately inform the Doctor so that he/she can refer me to the appropriate Doctor or Specialist for any medical concerns.

Patient Notification – Patient Portal

Please be advised Nationwide Optometry has implemented a Patient Portal. The Patient Portal is a secure website that allows you to use a computer to communicate and interact with the practice via secure messaging. As the Patient or the Patient's authorized representative or General Agent you understand if an email is provided a Patient Portal account will be generated and a welcome email sent.

Financial Acknowledgements

I hereby authorize any person/institution rendering care to furnish all facts concerning this claim. I authorize payment for my vision benefits to go directly to Nationwide Vision and Nationwide Optometry. I authorize Nationwide Vision and Nationwide Optometry to deposit checks received on my account made out to me for services rendered. **I agree that if my employer, insurance carrier or plan sponsor denies payment to all or any portion of my claim, I will be financially responsible for all outstanding charges.** In the event it should become necessary to place any unpaid balance due for services rendered to me or my family for collection, I/we agree to pay interest at the rate of 1.5% per month/18% per year, collection fees, and should legal action be filed, reasonable attorney fees, filing fees, and other costs the court determines proper. I have read the "Conditions of Service", and as the Patient, or the Patient's authorized representative or General Agent for the purpose of signing this document, hereby accept it's terms. **Authorization obtained at time of service does not guarantee payment and any denied services will be balance billed to the patient.**

Patient/Guardian Signature: _____ Date: _____

I have reviewed my previous Patient Information Form and there are no changes.

_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

Initial Date Initial Date Initial Date Initial Date Initial Date Initial Date

NATIONWIDE OPTOMETRY

NATIONWIDE™ VISION

Conditions of Service

Nationwide Vision, Richard Marrotte OD and Associates PA, Mark Peller OD and Associates PC

CONSENT TO TREATMENT: I hereby consent to any routine procedures, medical treatment or facility services rendered to the patient under the general and special instructions from the attending Optometrist/Ophthalmologist.

RELEASE OF INFORMATION: Subject to State and Federal regulations, Nationwide Vision, Richard Marrotte OD and Associates PA, and Mark Peller OD and Associates PC and/or provider may disclose all or any part of the patient's record for this service to any person or corporation which is or may be liable under a contract to the Optometrist/Ophthalmologist, or to a family member or employer of the patient for all or part of the provider's charges, including, but not limited to hospital or medical service companies, insurance companies, worker's compensation carrier, welfare funds and all authorized auditors as specified in the Insurance Carrier Guidelines and referring professionals.

I hereby authorize Nationwide Vision, Richard Marrotte OD and Associates PA, or Mark Peller OD and Associates PC to release to my insurance company information concerning any procedures performed during this office visit/treatment and the final diagnosis, as well as, information contained on this form.

RELEASE OF ACCOUNT INFORMATION: I understand any individual listed on the Authorization to Release Health Information form, the Patient Information form and any individual who can be reasonably assumed to will be authorized to retrieve any and all information pertaining to this account. This can include, but is not limited to, medical information relating to any person listed on the account as well as financial information and transactions. **Furthermore, if there are individual(s) whom I do not want authorized to access information, I will notify the facility HIPAA Compliance Officer in writing at Nationwide Vision 220 N. McKemy Ave. Chandler, AZ 85226 Attn: HIPAA Compliance Officer.**

CHECK AGREEMENT: I hereby agree to pay a service charge of $25.00 for each check or other instrument tendered by me, but returned Nationwide Vision, Richard Marrotte OD and Associates PA, or Mark Peller OD and Associates PC. I further agree to pay all costs and expenses, including attorney's fees which are incurred in collection on such a returned check, draft or money order.

PAYMENT AUTHORIZATION AND PAYMENT REMITTANCE: I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me released to Social Security Administration, its intermediaries or carriers any information needed to process any claim on this or any related services.

I certify that the information provided by me for all other Vision or Medical Insurance is correct and authorize the release to any intermediaries or carriers any information needed to process any claim on this or any related services.

I request that payment of authorized benefits be made in my behalf to Nationwide Vision, Richard Marrotte OD and Associates PA, or Mark Peller OD and Associates PC for its charges and for any charges of Optometrist/Ophthalmologist for whom the facility is authorized to bill in connection with its services.

RECEIPT AND ACKNOWLEDGEMENT OF PRIVACY PRACTICES: I hereby declare that I have read and understand the facility's Policy of Privacy Practices.

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