STATEMENT OF FINANCIAL POLICIES

It is the intent of Greider Eye Associates, to provide quality eye care in a cost effective manner. Therefore the following notice is necessary to ensure that all patients are informed of the financial policies of Greider Eye Associates.
A financial counselor is available to help with questions concerning billing and statements. Call the Billing Office at 760-758-2020.

Equal care will be provided to all patients, regardless of age, race, ethnicity, physical ability or attributes, religion, sexual orientation or gender identity as long as they accept responsibility for payment.

General Payment Policies

- FULL PAYMENT OR ACCURATE INSURANCE INFORMATION IS DUE AT TIME OF SERVICE.
- THERE WILL BE A $25.00 CHARGE FOR ALL CHECKS RETURNED AS "NSF" (NON-SUFFICIENT FUNDS).
- GREIDER EYE ASSOCIATES,WILL BILL CONTRACTED AND MOST NON-CONTRACTED INSURANCE COMPANIES.
- CASH PAY PATIENTS MUST PAY IN FULL AT THE TIME OF SERVICE OR PRIOR TO DATE OF PROCEDURE.
- PATIENTS ARE REQUIRED TO PRESENT A CURRENT INSURANCE CARD AND PICTURE ID AT EVERY VISIT; WITHOUT AN INSURANCE CARD YOU WILL BE REQUIRED TO PAY AT THE TIME OF SERVICE
- CO-PAYMENTS ARE DUE AT TIME OF SERVICE. A $25.00 CHARGE WILL BE ADDED TO ANY STATEMENT SENT TO A PATIENT FOR CO-PAYMENT.
- NO SECONDARY INSURANCE WILL BE BILLED FOR A CO-PAYMENT.
- A 24 HOUR NOTICE OF CANCELLATION OF APPOINTMENT IS REQUIRED; FAILURE TO PROVIDE THIS NOTICE WILL RESULT IN A CHARGE OF $25.00
- GREIDER EYE ASSOCIATES, WILL BILL SECONDARY INSURANCES FOR MEDICARE PATIENTS ONLY.

Payment of bills is expected upon receipt of our statement. Accounts become past due after thirty (30) days unless alternative arrangements have be previously made through the billing office.

Patients with a poor credit history must pay for their services on the date of service. Further credit may not be extended to patients until their account is current. Delinquent accounts are subject to collection at any time including at time of service.

A current MediCal card is required for MediCal billing and must be presented at each visit.

Contract Medicine Payment Policies
All patients are expected to pay any required co-payments at time of services. For medical services covered by their contract, no additional payments are required. However, patients will be required to pay for non-covered supplies, equipment, and services.

Medicare
Greider Eye Associates, does accept Medicare assignment. All patients without a secondary insurance will be responsible to pay the remaining balance after Medicare payment. All patients are responsible to pay for "non-covered" services. Patients may be required to sign an ABN.

Insurance Billing Information
Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid your account in full within sixty (60) days the balance may be automatically transferred to your responsibility for payment upon receipt of statement. It is the patient's responsibility to provide current insurance information to the practice.

Usual Customary Rates
Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients
The adult accompanying a minor and the parents (or guardians of a minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless authorization from guardian is provided in writing.

Signature: _____ Date: _____

Print Name: _____

Greider Eye Associates

Patient Information

Mr. Mrs. Miss Ms._____Today's Date:_____

Sex assignment at birth: M F Current gender ID: _____ Preferred Language:_____

Social Security Number:_____Date of Birth:_____/_____/_____

Drivers License #:_____Exp. Date:_____

Address:_____

City:_____State:_____Zip Code:_____

Home Phone:_____Cell Phone:_____

Work Phone:_____Email:_____

Employer:_____Occupation:_____

Business Address:_____

Patient Partner:_____Date of Birth:_____/_____/_____

Partner Work Phone:_____Cell Phone:_____

If Patient is a minor, Legal Guardian:_____Phone:_____

Emergency Contact Name:_____Phone:_____

PRIMARY CARE DOCTOR:_____Phone:_____

Referred By:_____☐ Doctor ☐ Optometrist ☐ Existing Pt.

☐ Family Member ☐ Co-Worker ☐ Friend ☐ Yellow Pages ☐ Internet ☐ Other

PRIMARY INSURANCE

1._____Policy#:_____

Insured's Name:_____Relationship to Pt:_____

Insured's SS#:_____Date of Birth:_____

SECONDARY INSURANCE

2._____Policy#:_____

Insured's Name:_____Relationship to Pt:_____

Insured's SS#:_____Date of Birth:_____

VISION PLAN:

3._____Policy#:_____

Insured's Name:_____Relationship to Pt:_____

Insured's SS#:_____Date of Birth:_____

Greider Eye Associates
Signature on File

I authorize the release of any medical information necessary to process all claims. _____
Initial

I understand that I am responsible for payment of my account regardless of insurance coverage or eligibility. _____
Initial

I understand that I am responsible for payment on my account for any non-covered items. _____
Initial

I request that the payment of authorized medicare, supplemental or any other insurance benefits be made on my behalf to Greider Eye Associates for services furnished me by that supplier. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine those benefits or the benefits payable to related services.

_____ _____
Signature Date

Refraction Service and Fee

One of the most important parts of your eye exam is the refraction. This is the part of the exam by which we determine whether you can be helped in any way by a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and look for problems. It is NOT a covered service by Medicare and many other insurance plans. These plans consider a refraction a “vision” service not a “medical” service. Our office fee for refraction is payable at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

_____ _____
Signature Date

Patient Acknowledgement

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at time of service. I understand that any co-payment, coinsurance, or deductible, I may have are separate from and not included in the refraction fee.

_____ _____
Signature Date

Health Information Sheet

Patient Name:_____ Age:_____ Date:_____

Primary Care Doctor: _____Phone:_____

List All Medications:_____

_____

_____

List all Medication Allergies:_____

Have you **EVER** taken a prostate or bladder medication? ☐Yes ☐No

If yes, please list:_____

Please check if you are currently having any of the following eye problems:

☐ Pain ☐ Burning, itching or scratching sensation ☐ Redness ☐ Tearing ☐ Discharge

☐Blurred or Fuzzy Vision Double Vision ☐Problems with glasses ☐ Flashing lights

☐ Cobwebs, dark spots or dark veils ☐Headaches

Please check any of these eye problems that you have had in the past:

☐ Cataract ☐ Glaucoma ☐Macular Degeneration ☐Eye injury ☐ Eye surgery

☐ Retina problem ☐ Muscle imbalance ☐ Double Vision ☐ Floaters ☐ Flashing lights

Do you currently wear contact lenses? ☐ Yes ☐No ☐Hard ☐Gas Permeable ☐Soft

General Medical History

Have you ever been diagnosed with: ☐ Diabetes ☐High Blood Pressure ☐ RA ☐ Lupus ☐ Stroke

☐ Cancer (type?)_____ ☐ Asthma ☐Thyroid Disease ☐ Heart Disease ☐ HIV Infection

Additional info:_____

List any surgeries you have had:_____

Review of Systems

Do you currently have any of the following problems:

	Yes	No	If yes, please explain
Chronic fever, unexpected weight loss, fatigue	☐	☐	_____
Ear, nose throat problems, sinusitis, hearing loss	☐	☐	_____
Heart problems, chest pain, irregular heart beat	☐	☐	
Respiratory problems, wheezing, cough, shortness of breath	☐	☐	
Gastrointestinal problems, diarrhea, vomiting, heartburn, pain	☐	☐	
Urinary problems, pain, discharge, blood in urine, urgency	☐	☐	
Skin problems, acne, seborrhea, eczema, psoriasis, rashes	☐	☐	
Musculoskeletal problems, aching, joint pain, joint swelling	☐	☐	
Neurologic symptoms, numbness, weakness, headaches	☐	☐	
Psychiatric problems, depression, anxiety, agitation	☐	☐	
Endocrine problems, thirst, temperature intolerance	☐	☐	

Family History

Check if any of the following conditions are in your family:

☐ Glaucoma ☐Strabismus ☐Retinal Disease ☐Cataract ☐Macular Degeneration

☐ Diabetes ☐Hypertension ☐Heart Disease ☐Cancer ☐ Other:_____

Social History

Smoking history: ☐ Never smoker ☐ Former smoker ☐ Current someday smoker ☐ Current everyday smoker

Pneumonia Vaccine : ☐Yes ☐No Flu Vaccine: : ☐Yes ☐No COVID19 Vaccine: : ☐Yes ☐No

GREIDER EYE ASSOCIATES

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Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____ understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment , and any plans for future care or treatment . I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for proper billing of provided service
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of Healthcare professionals,

I understand that I have a right to review Greider Eye Associates Notice of Privacy Practices, which provides a more complete description of information uses and disclosures, prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and any revised notice will be posted in the office. I understand that I may request a written copy of Greider Eye Associates Notice of Privacy Practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment and healthcare operations. I understand the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

I give consent to speak to the following individual regarding my treatment/services :

_____Relationship:_____

I fully understand and accept the terms of this consent.

_____ _____
Signature of Patient, Guardian or Representative* Date

_____
Print Name of Patient

_____
Print Name of Guardian or Representative

*If consent is signed by an individual's personal representative, the representative's authority is based on:

_____