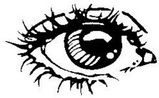


Burcham Eyecare Center

WELCOME TO OUR OFFICE

Our mission is to provide you with the most comprehensive and up to date eyecare.

INSURANCE IDENTIFICATION

We will make every effort to properly identify your coverage and to submit claims on your behalf to your carrier to obtain their payment. Your assistance is needed in this process. It is very important that you present your current insurance identification at the time of each visit to our office. The patient is responsible to know his/her insurance coverage. Please contact your insurance company prior to your appointment to see if your visit will be covered; some insurance plans do not have Routine Vision Coverage, or your Routine Coverage is through a secondary carrier, and some medical plans may have special networks, or require a referral.

OUT OF POCKET EXPENSES ARE REQUIRED AT THE TIME OF SERVICE

All out of pocket expenses, which are based upon the terms of your coverage are due and payable at the time the services are rendered. Co-payments, under the terms of your insurance coverage, MUST be made at the time of service. If you do not have health care coverage, we require payment in full at the time of your visit. We accept cash, check, Visa, Master Card or Discover.

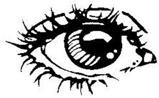
PAYMENT TERMS AND AGREEMENTS

I, the undersigned, in consideration for services rendered to the patient by Burcham Eyecare Center, understand and agree to the following:

1. I understand that payment for charges are due on the date of service with the exception of insurance coverage that Burcham Eyecare center is under contract to file directly.
2. I understand that my insurance coverage may not provide payment for all charges incurred in obtaining treatment from Burcham Eyecare Center. I will be responsible for any co-payment, deductible or services not covered by my insurance provider. If I do not have insurance I agree to pay all charges resulting from such services.
3. I hereby authorize Burcham Eyecare Center to file with my insurance carrier and I assign payments to Aurora Eye Physicians, P.C. our practice corporate entity.
4. I understand if I give Burcham Eyecare Center the wrong or invalid insurance information, I may be charged a $35.00 fee to re-file the claim. I further understand that this correction of insurance must be made to meet the insurance company timely filing requirements as part of our contract or I will have the charges transferred to me for payment.
5. I understand a fee of $25.00 will be added to my balance for a non-sufficient fund check that is returned to us by the bank.
6. I will keep my account current as to the charges for which I am responsible. In the event that I fail to pay charges, Burcham Eyecare Center will take whatever action necessary to collect such charges through their collection agency.
7. I understand that a fee of $50.00 may be charged for any appointment that I do not keep and have not canceled at least 24 hours in advance.

My signature below indicates that I have read and agree to the terms set above.

Signature:_______________________________________ Date:________________

 **Burcham Eyecare Center**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly or indirectly.**
- **Obtain payment from third-party payers, such as insurance or workman's compensation.**
- **Conduct normal healthcare operations such as quality assessments and physicians certifications.**

Any other uses of my protected health information will require my written release.

I acknowledge by my signature below I have read and reviewed the complete Notice of Privacy Practices for Burcham Eyecare Center.

I wish to retain a copy of the privacy notice: Yes _____ No _____

To help us serve you better please review and check the appropriate boxes below:

- **Family Members: Please check the appropriate boxes.**

  _____ I give Dr. Burcham or Dr. Stickelberger permission to speak to a family member about my treatment or care.

  _____ I do not give Dr. Burcham or Dr. Stickelberger permission to speak to another family member without my written consent.

- **Home telephone: Please check the appropriate boxes:**

  _____ Leave message with call back number only.

  _____ OK to leave detailed message on my home or cell phone voice mail.

  _____ OK to leave information with another family member who answers phone when I'm not available.

- **Work telephone: Please check the appropriate boxes.**

  _____ Leave message with call back number only.

  _____ OK to leave detailed message on my voice mail at work.

Patient Name (Print) ____

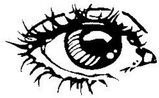
Relationship to Patient (self, mother, father, etc.) ___________________

Signature: _________________________________ Date: ______________

Office use only:

***Unable to obtain patient signature for the following reason*: __________________**

__________________________________ *Date:* __________ *Initials:* _________



Burcham Eyecare Center

Patient Information (Please print clearly)

Complete all appropriate sections and sign and date at bottom

Personal Information

Male or Female   Married   Single   Other   Mr.   Mrs.   Ms.

First Name: _______________ **Middle Initial:** ____ **Last Name:** _______________
Mailing Address: ____ **Apt #:** _________
City: __________________________ **State:** _____________ **Zip Code:** ___________
Home Phone #: ____________________ **Work Phone#:** ______________________
Cell#: __________________________ **Employed: None   FT   PT   Retired**
Employed by: _________________________ **Occupation:** ______________________
Date of Birth: ________________ **Current Age:** _______ **SS#:** ________________
***Email Address:** ____

* *(Only for the use of Burcham Eyecare Center for patient communications)*

Complete if patient is under 18 years of age or a student:

Name of Father: ____________________ **Fathers Employer:** __________________
Work Number: _________________
Name of Mother: ___________________ **Mothers Employer:** _________________
Work Number: _________________
Person Responsible for Bill: ____
Billing Address if different than patient's address: ____________________________
____

Insurance Information

Primary Medical Insurance: __________________ **Secondary:** _________________
Name of Primary Insured: ____
Routine Vision Insurance: ____
Primary Member Name: _________________________ **Primary DOB:** ___________
SS#: ____________________

Worker's Compensation (if treatment is for job related injury):

Date of Injury: __________________ **Employer:** ______________________________
Employer Contact Name: ____________________________ **Phone #:** ____________
Name of Carrier: ______________________________ **Claim #:** _________________
Address Claim should be mailed to: ____
____

Emergency Notification

Name: ___________________________________ **Relationship:** _________________
Address: ____
Home Number: _______________________ **Work Number:** _____________________

Patient or Parent Signature: ___________________________ **Date:** ______________

Who can we thank for referring you to our office: _____________________________

Burcham Eyecare Center

PATIENT NAME: ___________________________________ PRIMARY CARE DOCTOR:_____________________________

PHARMACY: _______________________________________ PRIMARY DOCTOR PHONE:___________________________

PHARMACY ADDRESS: _____________________________

ALLERGIES and/or MEDICATION SENSITIVITY: ____

* DO YOU CURRENTLY TAKE OR HAVE YOU EVER BEEN ON FLOMAX (A PROSTATE MEDICATION)? Y OR N

CURRENT HEALTH ISSUES	
Y or N	CURRENTLY PREGNANT OR BREAST FEEDING
Y or N	HIGH BLOOD PRESSURE _____# OF YEARS
Y or N	DIABETES IDDM / TYPE II _____# OF YEARS
Y or N	CANCER
Y or N	HEART DISEASE
Y or N	RESPIRATORY
Y or N	KIDNEY DISEASE
Y or N	CIRCULATION
Y or N	EAR/NOSE/THROAT
Y or N	STOMACH
Y or N	SKIN DISORDERS
Y or N	PSYCHIATRIC DISORDER
Y or N	BLOOD DISEASE
Y or N	ALLERGIC/IMMUNE
Y or N	THYROID
Y or N	MIGRAINES
Y or N	MUSCLE/SKELETAL
Y or N	OTHER (PLEASE SPECIFY):

CURRENT MEDICATIONS

DATE:	SURGERIES

DATE:	EYE SURGERIES

SOCIAL HABITS
TOBACCO:
ALCOHOL:
ILLICIT DRUGS:
OCCUPATION:

SIGNIFICANT FAMILY HISTORY	
DIABETES:	Y or N
GLAUCOMA:	Y or N
CATARACTS:	Y or N
HIGH BLOOD PRESSURE:	Y or N
HEART DISEASE:	Y or N
OTHER (PLEASE SPECIFY):	Y or N

PATIENT UPDATE: ________________________________ TECHNICIAN UPDATE: ______________________________________