Desert EyeCare Center

PATIENT UPDATE FORM

CONTACT INFORMATION

Patient Name: _____
First MI Last

Birth Date: _____ Today's Date: _____

Please **update any changes** to your phone number, address, or email on the lines below:

Phone: _____

Address: _____

Email: _____

MEDICAL VS. VISION INSURANCE

Desert EyeCare Center is required by law to follow proper coding and billing for eye/vision examinations.

Your vision insurance will only pay for a "well vision" exam if there is nothing wrong with the health of the eyes, but you suffer from focusing problems like nearsightedness, farsightedness, astigmatism, and presbyopia.

Your medical insurance will only pay for an exam if there is something wrong with the health of your eyes (for example: dry eye, cataracts, contact lens infection, glaucoma, etc.)

Initials: _____

Desert EyeCare Center may discuss my medical information and insurance information with:

Name: _____ Relationship: _____

HIPAA NOTICE AND ACKNOWLEDGMENT

I have been presented a copy of the Privacy Practices and have been offered a copy for my records.

Signature: _____

I request that payment of authorized insurance/Medicare benefits be made on my behalf to Desert EyeCare Center(DECC)/ Dr. Kelley Lawrence. This is to include medical services rendered by myself and/or dependents. I assume responsibility for any deductible, co-payment, or other balance not covered by my insurance carrier. Authorization obtained at the time of service does not guarantee payment. As a service to the patient, DECC will submit claims to your insurance carrier. However DECC cannot guarantee that these claims will be honored. All denied claims will be billed to the patient. I recognize that it is my responsibility to know and understand my insurance coverage, or lack thereof. I understand that professional fees are due upon completion of the exam, and that these services are non-refundable. I understand that all glasses and contact lens orders are non-refundable. I authorize the doctor to release all information necessary to secure payment of benefits.

Signature: _____ Date: _____