For Your Upcoming Appointment at Pocatello Eye Care

New Patients:

Please bring your photo ID, insurance card, or insurance information.

Most insurance companies *require* us to collect copay, which is **due at the time of service.**

If you **DO NOT** have insurance, payment in full is required at the time of service, unless you arrange to set up a payment plan with PEC in advance.

If possible, please print and complete your health profile prior to your appointment to save time at your appointment.

Bring a list of your current medications, dosages, frequency and schedule. Your pharmacy will do this at your request and can fax this directly to PEC– our fax number is 208-234-4192.

If you have been seen elsewhere for the same problem, please bring any related medical records or you can request your physician to fax them to PEC 208-234-4192.

Thank you! We are looking forward to serving you in your vision health care needs.

POCATELLO EYE CARE - PATIENT DEMOGRAPHIC INFORMATION

Please complete all information requested below. Please ask a staff member if you have any questions.

NAME (Last, First, MI): _____

DATE OF BIRTH *mm/dd/yyyy*:_____ GENDER: ☐ MALE / ☐ FEMALE

SS# : _____-_____ -_____

ADDRESS: _____

CITY/STATE/ZIP:_____

PRIMARY PHONE:_____ OTHER PHONE:_____

PREFERRED METHOD OF CONTACT for appointment confirmation: ☐ PHONE ☐ TEXT ☐ EMAIL

EMAIL ADDRESS: _____

EMPLOYER:_____

OCCUPATION (If retired, former): _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

SPOUSE'S NAME (If applicable):_____

PERSON(S) RESPONSIBLE FOR BILLING* **- Check here if the patient is responsible** ☐

NAME (Last, First, MI): _____

BIRTHDATE *mm/dd/yyyy*:_____

RELATIONSHIP TO PATIENT:_____

ADDRESS: _____

CITY, STATE, ZIP:_____

PRIMARY PHONE:_____ OTHER:_____

**Please note: Pocatello Eye Care may not be in-network with your insurance provider, which may result in higher patient responsibility for billing. Check with your insurance company regarding your insurance policy.*

PRIMARY INSURANCE COMPANY:_____

POLICY/MEMBER ID #: _____GROUP #:_____

NAME OF POLICY HOLDER: _____ COPAY: $_____

BIRTHDATE *mm/dd/yyyy* (If other than patient): _____RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE COMPANY:_____

POLICY/MEMBER ID #: _____GROUP #:_____

NAME OF POLICY HOLDER: _____ COPAY: $_____

BIRTHDATE *mm/dd/yyyy* (If other than patient): _____RELATIONSHIP TO PATIENT: _____

Please note: The Federal Government is now requiring Medical Providers to enter your race/ethnicity and primary language spoken. You may decline to answer these.

☐ Decline to answer

Please check:

Race	Ethnicity	Language
☐ American Indian / Alaskan Native	☐ Hispanic	☐ Chinese
☐ Asian	☐ Non-Hispanic	☐ English
☐ African American / Black	☐ Declined	☐ French
☐ Caucasian / White		☐ German
☐ Pacific Islander		☐ Japanese
☐ Other:		☐ Korean
☐ Declined		☐ Spanish
		☐ Other:

Patient Consent and Obligation

I acknowledge receipt of the ***Notice of Privacy Practices*** and accept and understand its terms. I authorize and request Physician and staff to provide me with any and all necessary evaluations and/or treatment. I authorize the release of/request for necessary information to/from physicians, facilities, and other caregivers that will aid in my diagnosis and care, including the review of my prescription history from external sources. I authorize the release of/request for necessary information to/from my insurance company that will aid in the payment for the services rendered. I authorize and request payment for services rendered be made directly to the Provider.

I agree to abide by the terms of the ***Patient Financial Policy*** and understand that insurance and filing does not release me from being responsible for accrued charges and agree to pay my bill in full within (90) days of receiving my first statement. I am aware that my account may be turned over to a third party collection service which may result in damaged credit, court costs, attorney fees, or garnished wages.

I give permission to Pocatello Eye Care to contact me regarding my medical needs by either phone, email, or text.

SIGNATURE:_____ DATE:_____

Revised 12/19/2019

Pocatello Eye Care
246 N 18th Ave, Pocatello, ID 83201
(208) 234-4100

Patient Financial Policy

Pocatello Eye Care is dedicated to providing our patients with the best possible care and service. Your understanding of this financial policy is an essential element of the services of your provider and Pocatello Eye Care. Fees associated with your surgeon usually include a clinical or hospital visit charge and a charge for your procedure or surgery.

Copay and Refraction Fees
We require your applicable office copayment at the time of your visit. In addition to your copay, you are responsible to pay $35 for refraction if you elect to have this test done. **Most insurances DO NOT cover this test.**

Late Arrival and Missed appointment
There will be a $25 charge for all missed appointments. If you are more than 15 minutes late to your appointment, your appointment will be cancelled and charged.

Procedure/Surgery
We require a prepayment prior to your procedure or surgery. This prepayment may include your remaining deductible and/or your estimated copayment and/or your coinsurance responsibility depending on your insurance plan. Failure to make your prepayment may result in the cancellation of your procedure/surgery.

Billing Process
After you have received care, we will bill your insurance. Once we receive insurance payment information, you will receive a statement with the remaining balance. This balance is due in full within ninety (90) days.

Discount for Insured Patients
Idaho Statute 41-348(b)(2) prohibits healthcare service providers from regularly waiving, rebating, giving, paying, or offering to waive, rebate, give, or pay all or a part of a claimant's deductible or claim for health insurance.

Private/Self Pay
Two payment options are extended to private/self-pay patients. The first is a twenty percent (20%) discount from charges if the amount is paid in full the day of the visit/procedure. The second is three equal payments split over 90 days.

Payments
Balances remaining thirty (30) days beyond your first statement will begin accruing interest at an annual interest rate of eighteen percent (18%). A $25.00 fee will be charged for all returned checks not honored by your bank. After 90 days if no payments have been made, this will result in your account being turned over to an outside collection agency.