

# MountainView Eye Associates, P.C.

## Welcome To Our Office

Welcome to MountainView Eye Associates, P.C.. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you are placing in us. Please take a moment to complete the following information. If you have any questions, please do not hesitate to ask.

First Name: \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

SS # \_\_\_\_\_ DOB \_\_\_\_\_ Home Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

e-mail: \_\_\_\_\_ Spouse or Parent: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_

Patient Status: (Circle All That Apply) Single Married Employed Full Time Student Part Time Student

Account Responsibility: Name, Ph & Address If Different From Above \_\_\_\_\_

How were you referred to our office? Advertisement? \_\_\_\_\_ Type \_\_\_\_\_

Patient? \_\_\_\_\_ Name \_\_\_\_\_ Doctor? \_\_\_\_\_ Name \_\_\_\_\_

**Primary Vision Insurance:** \_\_\_\_\_ Insured's Employer \_\_\_\_\_

Relationship to Insured?  Self  Spouse  Child  Other

Insured's First & Last Name: \_\_\_\_\_ MI \_\_\_\_\_ DOB \_\_\_\_\_

**Medical Insurance:** \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Insured's ID # \_\_\_\_\_ Group Name or Number \_\_\_\_\_

Relationship to Insured?  Self  Spouse  Child  Other

### PLEASE READ:

\_\_\_\_\_ In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered. If you are subject to a deductible or co-insurance, this will also be collected at the time of service. If we are unable to verify that your deductible has been met, you are responsible at the time of service for your payment. We will bill your insurance company for you and if we receive payment for services you have paid for, we will reimburse you for these expenses.

\_\_\_\_\_ I assign my insurance benefits to MountainView Eye Associates, P.C.. I understand that my insurance company is being billed for my services and / or materials today. I understand that my insurance company does not guarantee benefits and will pay my claim based on the information available when the claim is submitted. **I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR MY VISIT TODAY.**

\_\_\_\_\_ I understand that I have not presented any insurance benefits for my visit today. I also understand that MountainView Eye Associates will be unable to bill any insurance after services are rendered.

I UNDERSTAND MY OPTIONS FOR A COMPLETE RETINAL HEALTH CHECK TODAY.

I am choosing  OPTOMAP  Dilation At a cost of \$ \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_