



“We are limited, not by our abilities, but by our vision.”

WELCOME

Thank you for choosing Advanced Eye Care Center as your eye healthcare provider. Please remember to bring with you the New Patient forms completed, along with your insurance information cards and personal identification card. It is only necessary to arrive 15 minutes early to complete your check-in process. Late arrival or failure to have all the paperwork completed for your appointment may result in a delay in your appointment and possible reschedule. Our doctors require a complete dilated exam with refraction for a new patient which will allow them to address any eye care health needs you may have. Please plan on approximately 1 ½ hours for your visit time in our office.

If your insurance company requires a referral to see a specialist, you must bring the referral to your appointment to verify that our office has received the referral. If you are not sure whether or not you need an authorization or referral you should contact your primary care physician’s office. In addition, if your insurance company denies your claim due to a pre-existing clause, you will be responsible for any and all charges not covered by your insurance company.

At the time of your visit you will be expected to provide payment in the amount of any co-payment required by your insurance plan, any unmet annual deductible amount where appropriate, and any services that are not covered. Payments can be in the form of cash, check or any major credit card. A portion of a medical eye exam is called refraction (92015 CPT) and most insurance companies do not cover this portion or code. Please be prepared to pay \$48 for the refraction in addition to your co-payment and/or deductible.

We look forward to serving you with your eye care needs. Should you have any questions, please call us at 940-382-8000 so that we may assist you.



ADVANCED EYE CARE CENTER

2210 SAN JACINTO BLVD. #1
DENTON, TEXAS 76205
(940) 382-8000

OPHTHALMOLOGY • OPTOMETRY • OPTICAL

NEW PATIENT INFORMATION

PATIENT MUST BE ACCOMPANIED BY AN ADULT IF UNDER 18

PATIENT INFORMATION:

D.L. # _____ DATE _____

Mr. Mrs. Ms. Miss Dr.

NAME _____ DATE OF BIRTH ____ / ____ / ____ AGE _____ SEX F M

SOCIAL SECURITY NO. _____ (WE NEED THIS TO FILE YOUR INSURANCE CLAIM) MARITAL STATUS S M W D SEP

STREET ADDRESS _____ CITY _____ CELL PHONE () _____

STATE _____ ZIP CODE _____ HOME PHONE () _____

OCCUPATION:

EMPLOYER/SCHOOL _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ BUSINESS PHONE (INCLUDING AREA CODE) () _____

INSURED: (IF DIFFERENT FROM ABOVE)

NAME _____ DATE OF BIRTH ____ / ____ / ____ AGE _____ SEX F M

SOCIAL SECURITY NO. _____ RELATIONSHIP TO PATIENT _____

STREET ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ HOME PHONE (INCLUDING AREA CODE) () _____

EMPLOYER _____

EMPLOYER'S ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ BUSINESS PHONE (INCLUDING AREA CODE) () _____

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

NAME _____ PHONE NO. (INCLUDING AREA CODE) () _____

WHO IS YOUR MEDICAL DOCTOR? _____ DID HE/SHE SEND YOU TO SEE DR. SHAFRON? YES NO (PLEASE CIRCLE ONE)

HAVE YOU EVER MET DR. SHAFRON? YES NO HOW DID YOU HEAR ABOUT DR. SHAFRON?

FRIEND (WHOM MAY WE THANK) _____ RELATIVE _____ INSURANCE BOOK _____

NAME OF PHARMACY/LOCATION _____

PLEASE READ AND INITIAL:

PAYMENT IS EXPECTED AS SERVICES ARE RENDERED, UNLESS PRIOR FINANCIAL ARRANGEMENTS HAVE BEEN MADE.

IF INSURANCE IS TO BE FILED, THE PATIENT IS RESPONSIBLE FOR PRESENTING CURRENT INSURANCE CARDS AND PRIMARY CARE PHYSICIAN REFERRALS, IF NEEDED, AT THE TIME OF CHECK-IN. *PLEASE INITIAL HERE _____

SIGNATURE (RESPONSIBLE PARTY) _____



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Do not sign this form until you have read and fully understand its contents

NOTIFICATIONS & AUTHORIZATIONS

Financial Policy

Our office is a participating provider for Medicare and most insurance plans. It is the patient's responsibility to provide their most current insurance card(s) and/or referrals at each visit. If you fail to provide your current insurance information, it may be necessary to reschedule your appointment or we will accept you as a "self-pay" patient and expect you to pay in full at the time of service and we will not file an insurance claim for that date of service.

Payment for any co-pay, deductible, or co-insurance is expected at the time of check-in. If your insurance denies coverage, or does not pay for certain services, you will be financially responsible for these fees. For services rendered to minor patients, we expect payment from the adult accompanying the patient at the time of service. (Our staff does its best to advise you of any services not covered prior to the service).

This office does not file claims for insurance companies that we are not participating providers for and we only file a maximum of two (2) insurance companies. All tertiary insurance policies are the responsibility of the patient. Please know we are not Medicaid providers and cannot file any insurance claims to Medicaid.

I understand that any self pay fees, co-pays, co-insurances, and deductibles will need to be paid at the time of service.

Patient/Guardian

Date: _____

Assignment of Benefits

I authorize Advanced Eye Care Center to release any information necessary to my insurance carrier(s) to process medical claims. I assign all insurance benefits to be paid directly to Advanced Eye Care Center. A photocopy of this assignment is to be considered as valid as the original.

Patient/Guardian

Date: _____

General Consent for Treatment

I have requested medical services from Advanced Eye Care Center for myself and/or my dependent. I give permission to Advanced Eye Care Center to examine and treat myself and/or my dependent.

Patient/Guardian

Date: _____

Privacy Policy

I acknowledge that I have received or been offered a copy of Advanced Eye Care Center's Privacy Policy.

Patient/Guardian

Date: _____



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PATIENT'S FULL NAME _____
(please print)

CHART# _____

INSTRUCTIONS FOR LEAVING MESSAGES AND/ OR DISCLOSING YOUR PERSONAL HEALTH INFORMATION

	CIRCLE	
	YES	NO
COMMUNICATE ONLY TO ME		
OR		
OK TO GIVE INFO TO SPOUSE		
OK TO LEAVE INFO ON ANSWERING MACHINE		
OK TO GIVE INFO TO MY PARENT/ CHILDREN (NAMES) _____		
OK TO GIVE INFO TO CAREGIVER (NAMES) _____		
OK TO COMMUNICATE WITH ANY OTHER PERSON (NAMES) _____		

This directive will be considered in effect until revised in writing.

(SIGNATURE)

(DATE)

OTHER COMMENTS _____



Patient Office Policy

Office Hours: Office Hours are Monday through Thursday, 8:00am to 5:00pm and Friday, 8:00am to Noon.

Prescription Refills – As of Monday, September 1, 2008, we no longer handle prescriptions refill requests in person or over the phone. You are required to ask your pharmacy to fax in the request. Requests may be faxed to: (940) 383-2608. Please allow 24 hours from time of receipt from the pharmacy to process the prescription. Your prescription refill will only be processed if it included the correct name of the medicine, dosage, and instructions on how you are taking the medicine. Prescription refills will not be processed outside of normal business hours or after 12:00 pm on Fridays, nor weekends and evenings after the office has closed.

Physician Emergency on Call Policy – when the office is closed a physician is on-call 24 hours a day. The physician is to be contacted when the office is closed for **MEDICAL EMERGENCIES ONLY**. If you wish to make an appointment, have prescriptions refilled, obtain contacts or glasses you will not be called in over the weekend or when the office is closed. When attempting to contact a physician after office hours please remove any Caller I.D. or Call Intercept features that are operating on your phone line. Otherwise the physicians may be unable to contact you. In case of a true life threatening emergency call 911 or seek treatment at the nearest emergency room on weekends and after hours.

15 Minute Late Policy – If you are 15 minutes or later for your appointment you may be asked to reschedule.

Walk-In Appointments – Advanced Eye Care Center is an appointment only office. Examination by a physician cannot be guaranteed if you present to the office without an appointment.

Payment is expected at the time of service. Due to the high cost of billing, patients unable to make payment at the time of service will be rescheduled. Accepted methods of payment include cash, check, credit card, and debit card. We will file any insurance that is properly provided at the time of service. We require a photo ID from the patient in addition to insurance cards to file any insurance.

Form Completion – Please be aware that we need 7-10 business days to complete forms. Patients are required to pay a \$25 completion fee for disability forms. There is no charge for completing FMLA papers.

Coping of Medical Records – Patients requesting copies of their medical records will be assessed a \$25 fee for the first 20 pages and thereafter \$.50 a page. If an abstract is sent to a continuing care provider, there is no charge. An authorization for release of information must be signed and submitted before request for records will be processed.

No Show Policy – Patients who schedule appointments but fail to show up are documented as “no shows.” Patients who continue to “no show” may be charged a \$40 fee. In addition, patients with multiple “no shows” may be terminated from the practice. The definition of a “no show” is failing to cancel an appointment within 15mins of appointment.

Patient Termination Policy – Although it is an infrequent occurrence, a patient may be terminated from the office. It is at the discretion of the patients’ provider for any dismissal action. Common reasons for dismissal include, but are not limited to, use of foul language, chronic noncompliance with recommended therapy, non-compliance with medications, abusive behavior of staff, physicians, visitors or other patients. Once a patient is dismissed that record will not be re-opened for any provider in the practice.