Financial Policy

Thank you for choosing Cornea & Cataract Consultants of Nashville as your eye care specialists. In order to expedite the services you may require, please read the information below.

General information:

- If you are more than 20 minutes late for your appointment, you may be asked to reschedule.
- Please give our office a 24 hour notice of appointments that cannot be kept. **Failure to do so may result in a$50.00 no show fee.**
- Please bring a current list of all medications, both prescribed and over the counter with you.
- Please bring your current insurance card(s) and a photo ID to every appointment.

Financial Agreement:

As a courtesy, Cornea & Cataract Consultants of Nashville, will bill your medical insurance for services rendered, and then bill the patient/guardian for any remaining balance due, or non-covered service, after the insurance payment/adjustment is received and applied. Please note, our office does not accept vision plans. We only file medical insurances. An example of a non-covered service that is performed in our office is the refraction. The refraction is a test used to determine a patient's best-corrected vision. **Please let your technician know if you do not want this done prior to the exam being started in the event that your insurance will not cover it.**

If your insurance requires a referral (HealthSpring, for example), it is your responsibility to contact your Primary Care Provider to get this referral prior to your visit. In the event that we do not receive your referral, you may sign a financial waiver opting to pay for the visit. When the referral is obtained by our office, we will refund the money minus the copay and any non-covered services (if applicable).

Payment is due at check-out for copays, deductibles, non-covered services and any contact lens services, which may include a fitting fee and a supply of contact lenses. Contact lenses are not billed to any insurance company by our office. If you are not able to pay for contact lenses at the time of check-out, the lenses will not be ordered. At least half the amount due for contact lenses must be collected in order for contacts to be ordered and the remaining balance paid before they leave the office. There is a $10.00 fee for uncollected copays.

In the event that Cornea & Cataract Consultants of Nashville deem it necessary to pursue collections of a delinquent account through an attorney or collection agency, the patient/guardian will be responsible for all fees associated with this. These fees include a late/collections fee or $50 or 10% whichever is the greater amount.

For today's visit I am requesting that Cornea & Cataract Consultants of Nashville bill the following insurance(s):

Primary____ Secondary ____

By signing below, you agree to the information provided in this notice.

____ ____

Signature of patient/guardian **Date**

CORNEA & CATARACT CONSULTANTS OF NASHVILLE, PLLC
PATIENT REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT CLEARLY)

Mr., Miss, Mrs., Ms. (Please circle one)

Name: ______________________________ SS# ____________________

Date of birth: ____________ Sex: _________ Marital Status: ___________

Race: __________________ Ethnic Group: __________________________

Address: ____

City: ____________________ State: ________________ Zip: ___________

Home Phone: ___________________ Cell Phone: ______________________

Employer: _____________________ Work Phone: _____________________

Email address: ____

Emergency Contact: ___________________ Phone: ___________________

Referring Doctor: ____________________ Office Phone: ______________

Address/City/State/Zip: ____

PARENT/GUARDIAN/POWER OF ATTORNEY INFORMATION (please print):

Name: _____________________ SS# ________________ Race: ________

Date of birth: ________________ Sex: ______ Marital Status: ___________

Address: _________________________ City/State/Zip: _______________

Home Phone: ____________________Cell Phone: _____________________

Email Address: ____

Relationship to Patient
(Please circle one): Parent Guardian Power of Attorney

CORNEA & CATARACT CONSULTANTS OF NASHVILLE, PLLC
PATIENT REGISTRATION FORM

INSURANCE INFORMATION (Please print):

Primary Insurance: ______________________ Name of Policy Holder: __________________________

Policy Holder's DOB: ______________ Policy Holder's SS# _______________ Relation: ____________

Secondary Insurance: _____________________ Name of Policy Holder: _________________________

Policy Holder's DOB: ______________Policy Holder's SS#______________ Relation: ______________

Tertiary Insurance: _________________ Name of Policy Holder: _______________________________

Policy Holder's DOB: ___________Policy Holder's SS# ________________Relation: _______________

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1) I may be contacted by the office at: (check all that apply):
   _______ Home _______Work _______Cell _______E-mail

2) How did you hear about us?

   _____ Friend _____ Doctor Referral _____ Radio _____ TV _____ Magazine

3) May we leave account balance information on your answering machine?

   _______ Yes _______ No

4) Who, other than the noted emergency contact above, should be listed as an authorized individual we can release medical information to if needed?

   Name: ____________________ Phone: _________________Relationship:________________

PRIVACY NOTIFICATION:
I have received a copy of the Notice of Privacy Practices for Cornea & Cataract Consultants of Nashville. Cornea & Cataract Consultants of Nashville reserves the right to modify the privacy practices outlined in the notice.

By signing below, I acknowledge that I have completed the information to the best of my knowledge and I have read and understand and voluntarily consent to its contents:

_____________________________________ ____
Signature Date