Welcome to Our Office

Catino Eye Care

Patient Information

Last Name: _____ First name: _____ MI: _____

Address: _____

_____

Street City State Zip

Home # _____ Work # _____

Nickname: _____

Sex (Circle) M F Marital Status S M D W Birthday: _____

SSN: _____ Employer: _____

Occupation: _____

Race: _____ Ethnicity: _____ Communication Preference:

Text Email Telephone Mail

We are able to confirm and remind you of upcoming appointments via email and text messages!

Please enter information below ONLY if you wish to receive email and text messages

Cell # _____ Email: _____

Responsible Party (If other than patient)

Name: _____ Birthday: _____

First MI Last

SSN: _____ Employer: _____

Relationship: _____

Payment Policy & Acknowledgement - PLEASE READ AND INITIAL NEXT TO EACH STATMENT.

_____ Payment in full is expected at the time professional services are rendered and/or materials are ordered. We are happy to file insurance when applicable. Accounts 30 days past due may be subject to a charge of 1.5% interest per month.

_____ Failure to pay balances in the allotted time will result in patient incurring additional costs of collection including, but not limited to, attorney or legal fees, collection agency fees and finance charges.

_____ If insurance is filed on my behalf, I authorize my insurance benefits to be paid directly to Catino Eye Care.

_____ I agree unless Catino Eye Care and my insurer have a prior agreement, I am personally responsible for all non-covered services, co-pays and deductibles.

_____ I authorize the release of medical information to insurance carriers or other physicians if it is deemed necessary by my optometrist for financial or consultative purposes.

Patient/Responsible Party (Print): _____
Relationship: _____

Patient/ Responsible Party (Sign): _____
Date: _____

ACKNOWLEDGEMENT OF PRIVACY POLICY

Effective January 1, 2014

I have received, read and understood the Notice of Privacy Practices:

_____
Patient Name (Print)

_____
Patient/Responsible Party Signature Date

If there is anyone you would like to grant access to your account (including questions about balances / statements, protected health information and picking up glasses and/or contacts) please list the individual(s) below:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Catino Eye Care Financial Policy

(Revised March 2017)

Charges, co-pays and/or deductibles for medical services are due and payable at the time services are rendered. Payment may be made by cash, check, MasterCard, Visa, American Express or Discover.

For those with health insurance: We will file all services with your insurance company as a courtesy. You are responsible for providing a current insurance card at each visit. Co-pays and/or deductibles are due at the time services are rendered. **HDHP- High Deductible Health Plans,** based on your contract with your insurance plan, you are responsible for all medical bills until your deductible is met. Catino Eye Care staff will let you know your balance at check-out and collect payment at time of service. Should payment in full not be collected, a $40.00 payment towards your balance will be required. We will file your insurance and bill you for any remaining balance on your account, at which time the remaining balance will be due in full. Please be familiar with the benefits that your insurance provides. Catino Eye Care has no way to know all plan benefits of each insurance company, and it is your responsibilty to know your plan and plan benefits. You are responsible for any non-covered services or screenings that your insurance does not pay. If your account has not been settled in 90 days, it may be placed with collections and future services will be provided on a cash basis only.

For those with Medicaid: You must provide a current, signed Medicaid card at each visit.

For those who are uninsured: You must pay all charges on the date of service unless other arrangements have been made in advance with our office manager.

For patients under the age of 18: The parent/guardian bringing in the child for services is the person that is responsible (guarantor) on the account, regardless of which parent is providing insurance coverage.

For all patients: If your account is sent to collections due to lack of payment or not complying with payment arrangements made with our office manager, you will be dismissed from the practice.

Statements are mailed out monthly for all outstanding balances. Please send payment upon receipt. Financial arrangements can be made with our office manager if needed.

I _____ have read and accept financial responsibility as the patient or guarantor for services provided by Catino Eye Care.

Signature: _____ **Date:** _____

Advanced Beneficiary Notice (ABN)

- **Your insurance does not pay for all care, even those tests or procedures your vision care provider may recommend based on his or her professional expertise.**

- **This form acknowledges there are specific services not covered by your insurance, and there may be additional out-of-pocket costs for these services.**

- **You are responsible for payment for services not covered by your insurance. This would include routine retinal photos not covered by your medical insurance.**

Patient Name:_____ Date of Birth: _____

By signing below, I understand and approve the services listed above. I understand that if my insurance does not cover the service, I am responsible for payment.

Patient/Responsible Party Signature:_____ Date:_____

Providers: Gilbert Catino, OD Kelly Catino, OD