Spectrum Eye Care
Nathan L Scott, OD
P.O. Box 3100, 126 East Johnson Street, Chelan, WA 98816 • 509.682.2708 • FAX 509.682.2713

Thanks for making an appointment with Spectrum Eye Care! We are already preparing for your visit with us and look forward to seeing you soon.

There are a few very important considerations as you prepare for your appointment. Significant clerical delays do not allow enough time for our doctors to appropriately take care of you and delayed appointments are often rescheduled. This is not convenient for you or us.

Delayed and/or rescheduled appointments are best avoided by arriving 10 minutes before your scheduled appointment time with the following:

1. All forms in this packet completed using bold, black ink.
    a. Please do not use pencil or fine point pens as they do not scan well.
2. All insurance identification cards. If you have not yet provided us with your current insurance information or card, please do so as soon as possible. You may fax both the front and back of the insurance card to 509.682.2713.
    a. Insurance benefits must be verified prior to your appointment. Otherwise, payment will be expected at time of service.
3. Valid photo identification.
4. Bring any and all medications to your appointment, including any prescription medications and/or over-the-counter supplements.

Don't hesitate to call us with any questions or concerns. We are here to help you as much as possible. Otherwise, we look forward to seeing you at your appointment.

Spectrum Eye Care, Inc, PS - Patient Registration Form

PATIENT INFORMATION - Please complete this form in **bold, black ink**. Please fill in as completely as possible.

Patient's Name:_____

Mailing Address:_____

Physical Address:_____

City:_____ State:_____ Zip:_____

Daytime Phone:_____ Home Phone:_____ Cell Phone:_____

Do you prefer to receive calls at: ___Home ___Cell ___Work

*****Please Join our Online Community by Visiting www.spectrumeyecarechelan.com*****

Please share your or your family's email with us**:**_____

Communication preferred: _____email _____postal _____phone (Some communication must occur via postal mail, such as statements.)

Gender: M F Date of Birth:_____ Social Security Number:_____

Patient's Spouse / Significant Other_____ Phone:_____

Patient's Employer or School_____

Employer Address:_____ Phone:_____

City:_____ State:_____ Zip:_____

Emergency contact or nearest relative not living with you:_____ Phone:_____

Preferred Language: _____English _____Spanish _____Other - Please specify:_____

Race/Ethnicity: _____American Indian or Alaska Native _____Asian _____Black or African American _____Hispanic/Latino _____White

_____Native Hawaiian or other Pacific Island _____Other – please specify:_____

Whom may we thank for referring you to our clinic:_____

If patient is a minor, please provide name of parent or guardian:

Name:_____ Relationship_____

Individual responsible for account (if not the same as above):

Name:_____

Mailing Address:_____

Physical Address:_____

City:_____ State:_____ Zip:_____

Daytime Phone:_____ Home Phone:_____ Cell Phone:_____

Gender: M F Date of Birth:_____ Social Security Number:_____

Employer and Address:_____

INSURANCE INFORMATION ***P*LEASE PRESENT INSURANCE CARDS AND ID TO THE RECEPTIONIST****

Do you have medical insurance? Yes No Do you have vision insurance? Yes No

Signature of Legally Responsible Party Print Name Date

Print Dependent Name (If Applicable)

MEDICARE PATIENTS: Medicare does not cover the routine portion of your eye exam, called the refraction, which determines what your eyeglass prescription should be. Thank You!

Patient/Client Agreement

I, the undersigned, being the patient or being a person legally authorized to consent to services on behalf of the patient, do hereby voluntarily agree to the following conditions with Spectrum Eye Care, Inc, PS,:

1. **Provision of Accurate Information**: I acknowledge I have provided complete and accurate information regarding insurance coverage and current billing status.
2. **Release of Liability for Provision of Insurance Coverage Information**: I agree and understand that any verbal and/or written communication regarding insurance coverage for services and/or materials is for informational purposes, provided as a courtesy and does not guarantee any insurance coverage and/or payments. I acknowledge Spectrum Eye Care, Inc, PS, has provided this information as a courtesy at my request. Moreover, I am ultimately responsible for knowing the terms of my coverage. Furthermore, I agree to NOT hold Spectrum Eye Care, Inc, PS, responsible for any information provided to me regarding any insurance eligibility and/or coverage and agree to pay any remaining balances indicated by my insurance company or Spectrum Eye Care, Inc, PS, upon receipt of billing statement from Spectrum Eye Care, Inc, PS,.
3. **Consent and Authorization for Treatment**: I do hereby voluntarily consent and authorize Spectrum Eye Care, Inc, PS, and its provider and or agents to administer any treatment which may be deemed necessary and advisable for the diagnosis and treatment of the patient including: medical care, urgent or emergency care, surgical care, diagnostic tests, procedures, prescribing and administering drugs, medications, requested contact lens services, and other services that may be advisable for my health and well-being. I acknowledge that no representations, warranties, or guarantees as to results of cures have been made to me nor have I relied upon any such representations, warranties, or guarantees.
4. **Consent to Obtain Past and Present Medication History**: I give my permission and consent to allow Spectrum Eye Care, Inc, PS, to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.
5. **Authorization to Release Medicare and Medicaid Information**: I certify that the information provided by me in applying for payment from Medicare and/or Medicaid agencies is correct. I understand that health care services paid for under Medicare and Medicaid are subject to review by professional review organizations, which may recommend denial of payment if my condition does not warrant continued care. I hereby authorize those agencies responsible for determining eligibility under these programs to provide to Spectrum Eye Care, Inc, PS, and/or my physician(s), any information relating to the determination of my eligibility. I authorize Spectrum Eye Care, Inc, PS, to submit a claim to Medicare and/or Medicaid for payment. I request that payment of any bills for services furnished under the Medicare and/or Medicaid programs be made to either me or Spectrum Eye Care, Inc, PS, as the individual claim form and Spectrum Eye Care, Inc, PS, may direct.
6. **Advance Billing Notice/ Waiver of Liability**: Your physician, after history and physical examination, may recommend or advise certain tests and/or studies which Medicare, Medicaid, or other third party payor may determine to be medically unnecessary. If your physician or other health care professional(s) of Spectrum Eye Care, Inc, PS, have reason to believe that Medicare, Medicaid, or other third party payor may deny coverage, you will be so informed and requested to sign an Advanced Billing Notice (ABN) and/or other waiver acknowledging you have been informed of such information and are agreeing to pay Spectrum Eye Care, Inc, PS, for these services if Medicare, Medicaid, or other third party payor deny benefit payment. Your physician will only recommend and/or advise studies and/or tests, which he/she deems to be in your best interest.
7. **Medicare Lifetime Beneficiary Authorization** (APPLIES TO MEDICARE PATIENTS ONLY): I hereby request that payment of authorized Medicare benefits be made either to me or on my behalf to Spectrum Eye Care, Inc, PS, as the individual claim form and Spectrum Eye Care, Inc, PS, may direct for any services furnished me by Spectrum Eye Care, Inc, PS. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services (CMS) and/or Health Care Financing Administration (HCFA) and its agents any information needed to determine benefits or benefits for related services.
8. **Authorization to File Insurance Automatically**: I hereby request and authorize Spectrum Eye Care, Inc, PS, to file claims automatically after services have been rendered me. I will advise in writing to Spectrum Eye Care, Inc, PS, any alteration to this request and authority.
9. **Payment**: I agree and understand that I have a responsibility to pay for ALL services and/or materials provided by Spectrum Eye Care, Inc, PS, and may ask at any time about fees for specific services and/or materials. In the event that a balance is due at or following the time of service(s) and/or ordering or dispensing of material(s), I agree to pay all outstanding balances in full. I agree to pay any balance(s) that remain unpaid by my insurance after 90 days following time of service(s) and/or ordering of material(s). I also agree and understand that Spectrum Eye Care, Inc, PS, may charge a fee up to $10 per statement for balances past due over 30 days. I guarantee the full and complete payment of all charges for care rendered and materials ordered on my behalf by Spectrum Eye Care, Inc, PS, and its physicians. This is a guarantee of payment and not merely of collection, and I agree to be directly responsible for the payment of all charges. If I fail to pay any outstanding balances and it becomes necessary for Spectrum Eye Care, Inc, PS, to institute collection efforts against me, I agree to pay Spectrum Eye Care, Inc, PS, all costs of collection thereof, including reasonable attorney's fees incurred in connection therewith. I further agree that this authorization provides consent for Spectrum Eye Care, Inc, PS, to release and obtain credit information from the area Credit Bureau and Collection Agency.
10. **Assignment of Insurance Benefits** (not including Medicare): I hereby authorize payment directly to Spectrum Eye Care, Inc, PS, of vision, durable medical goods and/or services, medical and/or surgical benefits otherwise payable to me. I understand that I am financially responsible to Spectrum Eye Care, Inc, PS, for its services in connection with treatment rendered during encounters. Any such excess amount (unapplied credit) may first be applied to payment of any other indebtedness due by me or my legal dependents for other treatment rendered and the balance, if any remains more than $20, shall be paid to me. I agree account credits less than $20 may remain for future use or until refund is requested in writing.
11. **Minor Patients/Legal Dependents**: For all services rendered and materials dispensed, the legally responsible party(ies) is(are) bound by these terms.
12. **Personal Property**: Spectrum Eye Care, Inc, PS, is not responsible for personal property worn or carried onto the property. Every precaution will be taken to assure no loss; however, patients are urged not to wear jewelry which may need to be removed for examination, diagnostic testing, or treatment.
13. **Appointment Cancellation**: If you are unable to cancel your appointment 24 hours in advance, you may be subject to a $50 no show fee.
14. **This Agreement Supersedes Any Prior Patient-Client Agreements**: I acknowledge that this signed Patient Client Agreement replaces and supersedes any other Patient Client Agreement between myself and Spectrum Eye Care, Inc, PS. I also acknowledge this is my written notice of such.
15. **Acknowledgement of Privacy Practices**: I acknowledge that I have been given the opportunity to review and/or have received a current copy of Spectrum Eye Care, Inc, PS, Notice of Privacy Practices.

I have read and understood and agree to the above provisions pertaining to my relationship with Spectrum Eye Care, Inc, PS. I acknowledge all questions pertaining to any part of this agreement have been answered to my satisfaction and complete understanding. This agreement will remain in effect until revoked by me in writing. A photocopy of this agreement for treatment, signature on file, assignment of benefits and financial agreement is considered to be as valid as the original.

Signature of Legally Responsible Party | Print Name | Date

Print Dependent Name (If Applicable)