Boise Vision Care

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Patient Name: Click here to enter text.
Address: Click here to enter text.
City/State/Zip: Click here to enter text.
Home Phone: Click here to enter text.
Day Phone: Click here to enter text.
DOB: Click here to enter text.
SSN#: Click here to enter text.
Occupation: Click here to enter text.

Insurance: Click here to enter text.
Insurance ID: Click here to enter text.
Name of Primary Member on Insurance:
Click here to enter text.
Primary Member's DOB:
Click here to enter text.
Subscriber's Employer: Click here to enter text.
E-mail: Click here to enter text.

Communication Pref. for Appointments (check all that apply): ☐ E-mail ☐ Postal ☐ Telephone-Text
Sunglasses: Own ☐ Interested In ☐ Contact Lenses: Current Wearer ☐ Interested In ☐

- I acknowledge I have reviewed/been given the opportunity to review the **Notice of Privacy Practices**. (Copy available upon request.)
- I will receive a copy of my finalized/completed glasses and contact lens prescriptions.
- I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services. I request that payment of authorized insurance benefits for any services furnished me, be made on my behalf to Boise Vision Care, P.A.
- Services are rendered and charged to the patient, not the insurance company. We are happy to file a claim for you, but we cannot accept responsibility for collecting or negotiating a settlement on a disputed claim. Fees not paid by your insurance company and insurance balances aged 90 days will be your responsibility. Unpaid patient balances aged 60 days or more will incur a minimum $5/maximum 5% monthly finance fee. Patient balances aged over 90 plus days will be turned over to collections.
- Once an order is started by the lab, it cannot be canceled. The patient is responsible for the balance.
- Boise Vision Care has attempted to verify my benefits using information I provided. My insurance company does not guarantee any benefits to Boise Vision Care. I am responsible for knowing my benefits and selecting my healthcare provider, whether in or out-of-network.
- **Once an order is started by the lab, it cannot be canceled. The patient is responsible for the balance**

Notice of Non-Covered Services

- This notice is to inform you that your health plan may not cover the service fee(s) listed or materials for the following reason(s):
  - The service(s) are excluded under your plan.
  - Any overages on materials or material fees that are not covered under your plan.
  - Prior authorization is required and has not been received or has been denied.
  - * Subject to insurance policy deductible, co-pay, or co-insurance

Refraction 92015 $45.00 - Retinal Screening 92250-52 $39.00 - Contact Eval 92310 $47.00
*Diabetic Retinal Screening 92250-52 $39.00 - *Medical Retinal Photo 92250 $108.00

By signing, I acknowledge that I have read and understand each statement. I verify that all personal information is correct and that I will have access to my prescriptions.

Adult Signature: _____ Date: _____