Welcome to Unger Eye Care

Thank you for trusting your vision and eye health to the doctors and staff of Unger Eye Care since 1991. We are truly blessed to have the opportunity to raise our family and serve our patients in the Troy and surrounding communities.

Patient Information: Name:______________________________

(Please Print) First Mi Last Suffix: Nickname:

Address:______________________________

Street Apt # City State Zip

DoB:______________ Male / Female SSN:______________ (full # may be needed for insurance purposes)

Last 4 digits

Preferred Language: English / Other ______________ Ethnicity: Hispanic/Latino, Other, Declined

(circle one)

Race: Caucasian, African American, American Indian, Hawaiian, Asian, Other, Multiracial, Unknown, Decline

Contact Information:______________________________

(Please circle prefered phone number) Home Mobile Work Email

Employment/School:______________________________

Employer or School Occupation or Grade

Referral Information: How did you hear about our office? (circle all that apply)

Facebook, UngerEyeCare.com, Google search, Newspaper, Phone book, Insurance, Marketplace Magazine, Friend ________________, Other ________________

Family Members: Please list any family members who are or may be in the future a patient in our office. Please indicate who in the household is responsible for payment and receiving billing notices by checking the box.

❑ ______________________________

Name DOB SSN (Last 4 digits) Relationship (spouse, child, parent, step child etc)

❑ ______________________________

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Doctors & Pharmacy:

Primary Care Doctor:______________________________

Name Office/Group Name Phone

Endocrinologist, Rheumatologist, or other specialist:______________________________

Name Phone

Pharmacy:______________________________

Name Location Phone

Things you will need to bring to your exam

- ❑ Medication list
- ❑ All glasses and sunglasses
- ❑ Contact lens boxes or blister pack
- ❑ Insurance cards
- ❑ Photo ID

Insurance Information:

Please present your insurance cards to the front desk for scanning. We can not file insurance for you without having a current card on record. Does your primary medical insurance require a referral? YES / NO

Primary Medical: ____

Company Name | Policy Number | Group Number | Guarantor Name | Specialist Copay

Secondary Medical: ____

Company Name | Policy Number | Group Number | Guarantor Name

Vision Plan: ____

Company Name | Policy Number | Guarantor Name | Copay

Do you have a Flex Spending Plan, HSA, or Cafeteria plan? ______________ Is it active ____________

Financial Assignment and Agreement

1. Please remember that insurance is considered a method of reimbursing the patient to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

2. Payment is expected to be paid at the conclusion of each visit unless our office participates in your insurance or other arrangements have been made prior to your visit.

3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to be released to the health care financing administration, it's agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.

4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

5. If Unger Eye Care has not heard from my insurance within 60 days of submission, I will be responsible for any balance due.

6. If, during an examination, a medical diagnosis is found, your exam may no longer be considered routine and may be sent to your primary medical insurance rather than an associated vision plan. All applicable specialist co-pays, deductibles, and coinsurance may apply. As a benefit to our patients we will coordinate the medical and vision plans.

7. A 1% interest will be charged per month on any accounts past due. If my account becomes assigned to a collection agency, I agree to pay all costs of collection, all agency fees, all court costs, and all attorneys fees as allowed by law.

8. I understand that this serves as my signature on file for all insurance and records release purposes.

9. I understand that there is a return check fee of $25. Return check fees are assessed on any bad/returned check including ACH payment plans. $25 will be assessed on each occurrence. Return check fees may be withdrawn automatically from your financial institution as soon as funds are available.

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Signature | Date | Full Printed Name