For Your Upcoming Appointment at Pocatello Eye Care

New Patients:

Please bring your photo ID, insurance card, or insurance information.

Most insurance companies *require* us to collect copay, which is **due at the time of service.**

If you **DO NOT** have insurance, payment in full is required at the time of service, unless you arrange to set up a payment plan with PEC in advance.

If possible, please print and complete your health profile prior to your appointment to save time at your appointment.

Bring a list of your current medications, dosages, frequency and schedule. Your pharmacy will do this at your request and can fax this directly to PEC– our fax number is 208-234-4192.

If you have been seen elsewhere for the same problem, please bring any related medical records or you can request your physician to fax them to PEC 208-234-4192.

Thank you! We are looking forward to serving you in your vision health care needs.

Explanation of Refraction Charge
Pocatello Eye Care
246 N 18th Ave, Pocatello, Idaho 83201

Refraction is a measurement that determines your best vision. It is *necessary if you would like a* ***new glasses prescription, contacts lenses or if you have noticed a change in your vision.*** Determining your best vision is the only way to begin an accurate evaluation of eye health. If your vision is less than 20/20 we will need to perform a refraction using any of several precise instruments, as well as the expertise of our certified ophthalmic techs and our physicians.

Medicare and several other forms of insurance **DO NOT** consider Refraction to be part of a comprehensive eye exam and will not pay for this service. Additionally, if Medicare does not cover your refraction neither will, the secondary insurer. **Commercial carriers may cover the refraction.

Who has decided that Refraction is not covered? Our government (for Medicare and Medicaid) or your insurance company determines exactly which services are covered, **NOT** your physician.

Our policy, in order to provide the very best eye care, is to perform a refraction for all new patients and those presenting with decreased vision.

Patients are responsible for paying the refraction fee of $35 at the time of service in addition to any co-payments or deductible due.

***I understand that refraction is a non-covered service. I accept full financial responsibility for the cost of this service in addition to any co-payments or deductible.*

_____ _____

Patient Signature or Guardian Date

A. **Notifier:** Pocatello Eye Care 246 N. 18th Ave. Pocatello, ID 83201 (208)234-4100

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.Refraction** below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D. Refraction** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Refraction	May not meet medical necessity of Medicare guidelines.	$35.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. Refraction** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.Refraction** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

ACKNOWLEDGEMENT OF PRIVACY NOTICE

John M. Fornarotto, M.D. / Ryan Johnson, O.D. / Bradley J. Anderson, M.D.
Pocatello Eye Care
246 N 18th Ave., Pocatello, ID 83201
Phone: (208) 234-4100 Fax: (208) 234-4192

□ YES □ NO I understand what the Notice of Privacy Practice is.

□ YES □ NO I would like a copy of the Notice of Privacy Practice.

□ YES □ NO I give permission to PEC to contact me regarding my medical needs by either phone, email, or text.

Patient Signature* (Parent for Minor) Date

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RELEASE OF MEDICAL RECORDS

I give permission to release my medical records to the following:

Name of patient

Patient Signature* (Parent for Minor) Date

*If not signed by the patient, please indicate relationship:

- □ Parent or legal guardian of minor patient
- □ Guardian or conservator of an incompetent patient
- □ Beneficiary or personal representative of deceased patient

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FOR OFFICE USE ONLY

Employee receiving signed form Date

□ Acknowledgement refused.

Efforts to obtain:

Reason for refusal:

POCATELLO EYE CARE - PATIENT DEMOGRAPHIC INFORMATION

Please complete all information requested below. Please ask a staff member if you have any questions.

NAME (Last, First, MI): _____

DATE OF BIRTH *mm/dd/yyyy*:_____ GENDER: ☐ MALE / ☐ FEMALE

SS# (At least last 4 digits): _____-_____-_____

ADDRESS: _____

CITY/STATE/ZIP:_____

PRIMARY PHONE:_____ OTHER PHONE:_____

PREFERRED METHOD OF CONTACT for appointment confirmation: ☐ PHONE ☐ TEXT ☐ EMAIL

EMAIL ADDRESS: _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

SPOUSE'S NAME (If applicable):_____

EMPLOYER:_____

OCCUPATION (If retired, former): _____

PERSON(S) RESPONSIBLE FOR BILLING* - **Check here if the patient is responsible** ☐

NAME (Last, First, MI): _____

BIRTHDATE *mm/dd/yyyy*:_____

RELATIONSHIP TO PATIENT:_____

ADDRESS: _____

CITY, STATE, ZIP:_____

PRIMARY PHONE:_____ OTHER:_____

**Please note: Pocatello Eye Care may not be in-network with your insurance provider, which may result in higher patient responsibility for billing. Check with your insurance company regarding your insurance policy.*

PRIMARY INSURANCE COMPANY:_____

POLICY/MEMBER ID #: _____GROUP #:_____

NAME OF POLICY HOLDER: _____ COPAY: $_____

BIRTHDATE *mm/dd/yyyy* (If other than patient): _____RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE COMPANY:_____

POLICY/MEMBER ID #: _____GROUP #:_____

NAME OF POLICY HOLDER: _____ COPAY: $_____

BIRTHDATE *mm/dd/yyyy* (If other than patient): _____RELATIONSHIP TO PATIENT: _____

Please note: The Federal Government is now requiring Medical Providers to enter your race/ethnicity and primary language spoken. You may decline to answer these.

☐ Decline to answer

Please check:

Race	Ethnicity	Language
☐ American Indian / Alaskan Native	☐ Hispanic	☐ Chinese
☐ Asian	☐ Non-Hispanic	☐ English
☐ African American / Black	☐ Declined	☐ French
☐ Caucasian / White		☐ German
☐ Pacific Islander		☐ Japanese
☐ Other:		☐ Korean
☐ Declined		☐ Spanish
		☐ Other:

I authorize payment of medical benefits to the physician or supplier for the care and services rendered. I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or any family member. I understand that it is my responsibility to make sure the bill is paid within 30 days. All collection costs and attorney fees are incurred by the patient if not paid as agreed.

SIGNATURE:_____ DATE:_____