Lafayette Eye Associates, P.C.
413 Germantown Pike
Lafayette Hill, PA 19444
Phone: (610) 825-3937
www.LafayetteEye.com

WELCOME TO LAFAYETTE EYE ASSOCIATES!

Patient Information Form

Salutation: _____ First Name: _____ Last Name: _____ MI: ____ Suffix: _____
Date of Birth: _____ / _____ / ____ Home Tel: _____ Cell: _____ Email: _____
Address: _____ City: _____ State: ____ Zip: _____

Parent / Guardian: _____ Emergency Contact & Phone: _____
First visit with us? Who can we thank for referring you to our office? ☐ Doctor: _____ ☐ Friend: _____ ☐ Other: _____

Insurance Authorization and Binding Financial Responsibility

Providing the best possible care involves a mutual understanding between the patient and provider. Should you have any questions about the following policies, please ask for clarification. Our professional services are rendered to you, not your insurance company. Ultimately, payment for the services rendered to you is your responsibility.

- I authorize Lafayette Eye Associates, P.C. to bill my insurance companies and vision care plans for services rendered to me and with payment made directly to Lafayette Eye Associates, P.C. and that such authorization is valid until written notice is provided to cancel that authorization. I authorize Lafayette Eye Associates, P.C. to release any information required to process any and all claims for reimbursement on my behalf.
- I understand that I am financially responsible for any charges stemming from services and materials (i.e. frames, lenses, contact lenses) rendered not paid by my insurance companies or vision care plans. Submitting a claim on my behalf is not a guarantee of payment by my insurance company or vision care plan and could result in a patient balance due to my selection of an insurance plan with an annual deductible. If co-payments and / or deductibles are designated by my insurance company, health plan or vision care plan, I agree to pay them to Lafayette Eye Associates, P.C.
- I understand there may be medical findings during the course of my exam. I understand it is a violation of Lafayette Eye Associates, P.C.'s provider agreement with my insurance company to bill such medically related services to my vision care plan. In the event my medical insurance will be billed, I understand I will be responsible for any applicable copays, cost-shares and / or deductibles as per my agreements with my insurance company and vision plan. I also understand that Lafayette Eye Associates, P.C.'s will not neglect medical findings in order to bill my vision care plan, as that would put Lafayette Eye Associates, P.C. in direct conflict with its ethical obligations to the Pennsylvania Board of Optometry.
- I understand that if I fail to pay my patient balance in a timely manner, then interest charges and late fees may accrue.
- I understand that knowing my insurance and vision care plan benefits is ultimately my responsibility.

I understand and agree to all of the statements made herein and that this is a binding agreement.

Signature: _____ Date: _____

Responsible Party Name (if applicable): _____ Signature (if applicable):_____

Patient Portal and Communication Notice

Committed to providing you with the highest quality of care, Lafayette Eye Associates, P.C. makes your medical records, upcoming appointment information, order status of eyeglasses & contact lenses, outstanding account balances, direct private communication with your doctor, among other things available through our electronic patient portal. Lafayette Eye Associates utilizes a third-party communication platform (Solution Reach) to assist us with confirming upcoming appointments and keep you compliant with your eye care treatment plan through a combination of phone calls, emails and text messages. If you prefer not to be contacted through one of these channels on the communication platform and take responsibility for coordinating your own care, please indicate your wishes in writing below the signature line.

I have read this paragraph and understand the communication policies of Lafayette Eye Associates.

Signature: _____ Date: _____

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Patient Information Form (continued)
Notice of Privacy Practices / HIPAA Authorization

By signing below, you attest that you have been informed of / offered this practice's privacy policy and the rights to privacy that you are afforded by federal legislation (HIPAA Privacy Act). The privacy policy outlines how your information is shared only for the purpose of performing service or collecting payment. I am free to refer to this policy at any time. These policies are subject to change or modification as legislation changes.

I give permission to Lafayette Eye Associates, P.C. to discuss or release health information identifying me to my insurance companies, referring / consulting physicians, and the following authorized people / entities: _____

Signature: _____ Date: _____

Contact Lens Care and Evaluation Services

At Lafayette Eye Associates, we aim to provide you with the best possible contact lens service for your needs and make available to you the most updated technology. Insurance companies may only cover the cost of your eye examination, which includes an evaluation of your general eye health and updating your eyeglass prescription. A contact lens prescription is not the same as an eyeglass prescription. As a contact lens wearer, additional tests and measurements are required to make sure that your eyes are healthy, that your lenses fit properly and to ensure that you are seeing as well as possible in your contact lenses. The proper size, curvature, lens power, and material are things considered when determining the right contact lens for you, which may take several visits to finalize. The fee for a contact lens care and evaluation varies based on the complexity of the contact lens fit (i.e. astigmatism, rigid gas permeable, bifocal, multifocal, scleral). By law, a contact lens prescription is valid for only one year.

I have read this paragraph and understand that I am financially responsible for fees not covered by my insurance related to contact lens services rendered.

Signature: _____ Date: _____

Responsible Party Name (if applicable): _____ Signature (if applicable):_____