Bayview Vision Clinic
15821 SR 525
Langley WA 98260
P. (360) 321-4779
F. (360) 321-4782

Name: _____ **DOB:** _____ **Gender:** _____ **SSN last 4** _____

Mailing Address: _____ **City/State:** _____ **Zip Code:** _____

Cell Phone Number: _____ **Home Phone Number:** _____

Email Address: _____ **Employer:** _____

Emergency Contact: _____ **Phone Number:** _____ **Relationship:** _____

Primary Care Doctor: _____ **Pharmacy:** _____

If insurance card not present please fill out information below.

Primary Insurance: _____ **Policyholder Name:** _____ **Relationship to patient:** _____

Policy Holder Date of Birth: _____ **Policy ID Number:** _____ **Policy Group Number:** _____

Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of the visit. This includes but is not limited to; Refractions(glasses Rx) and contact fittings.

Please bring your photo ID and Insurance cards to every appointment.

Notice of Privacy Practices

We are concerned with your privacy rights. We are complying with national guidelines (HIPAA) to safeguard your personal health information.

We keep a record of the health care services we provide to you. You may ask to view and/or obtain a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or receive more information about it by contacting our privacy officer or any front office staff member.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information. If you would like a copy for your review, please request a copy from our reception staff.

By my signature below, I acknowledge being informed of your privacy practices, and my right to obtain a copy of the full "Notice of Privacy Practices." My signature also is acknowledgment & acceptance of the other policies listed above.

Print Name: _____ **Sign Name:** _____ **Date:** _____

Bayview Vision Clinic
15821 SR 525
Langley WA 98260
P. (360) 321-4779
F. (360) 321-4782

Bayview Vision Clinic Payment Policy

Thank you for choosing Bayview Vision Clinic. We are committed to providing you with quality and affordable health care. We have developed this to help patients understand their responsibility for services rendered at our clinic. If you have any questions please do not hesitate to speak to our staff.
Please read each of the policies listed and sign below.
By signing below, you acknowledge that you have read and understand each specific policy.

Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Copayments and deductibles. All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. It is your responsibility as the insured to know of any deductible you may have. Some or all services may be applied towards your deductible, please contact your insurance company if you have any questions on coverage.

Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Nonpayment. If your account is over 90 days past due, you will receive a phone call notifying you that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Missed appointments. We require a 48-hour notice of cancellation to allow us time to fill the appointment slot. If you no show or cancel an appointment after the 48 hour time period there may be a $45 dollar no show/ cancellation fee. If you no show or late cancel twice in a calendar year without explanation we reserve the right to no longer see you as a patient at Bayview Vision Clinic.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Print Name: _____ **Sign Name:** _____ **Date:** _____

Bayview Vision Clinic
15821 SR 525
Langley WA 98260
P. (360) 321-4779
F. (360) 321-4782

Permission to Disclose Information

Patient Name:_____

Patient Date of Birth:_____

Patient Email Address:_____

I give my consent to Bayview Vision Clinic to disclose my person health information, treatment(s), appointment details, and payment information to the following person(s) listed below:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Bayview Vision Clinic may leave a detailed message on my answering machine regarding current and future appointment that I have scheduled.

□ YES □ NO

Bayview Vision Clinic may send me an email to my personal email address that I provided regarding my personal health information, treatments, appointment details, and payment information.

□ YES □ NO

I understand that I may change, suspend, terminate, and revoke any person from this list at any time, in writing. Furthermore, I acknowledge that Bayview Vision Clinic will NOT disclose any information to anyone who is not on this list.

_____ _____

Patient Signature **Date**