SUNNYVALE OPTOMETRY

Patient Name _____ M ____ F ____ *Required for insurance filing

Date of Birth _____ S.S. Number (last 4 digits) _____

Address _____ Apt/ Unit # _____

City, State, Zip Code _____

Cell Phone _____ Work Phone _____

Home Phone _____ Email _____

(By providing phone number(s) and/or email(s), you are consenting to be in communications with Sunnyvale Optometry via such manner(s))

Patient's Occupation _____ Employed by _____

Emergency Contact _____ Phone _____

Vision Insurance _____ Medical Insurance _____

Insured's Name _____ Insured's DOB/ SSN _____

Patient's relation to insured: Self _____ Spouse _____ Child _____ Other _____

Referred by: _____

Person responsible for account: _____

I acknowledge that I have been informed by copy/website of Sunnyvale Optometry's Notice of Privacy Practices

Signed: _____ Date _____ Updated _____ Updated _____ Updated _____

FINANCIAL RESPONSIBILITY POLICY

Effective September 1, 2019, Sunnyvale Optometry will submit claims for products/services to a patient's primary insurance carrier only. With the exception of VSP vision plans, any and all claims to secondary/tertiary insurance(s) will be the responsibility of the patient. **We will no longer be coordinating (COB) your medical insurance with any other form of insurance(s) for any medical services and/or special tests/procedures.**

Your insurance policy is defined by your insurance carrier. Plan coverage does not mean 100% insurance payment. We will make every effort to verify your insurance eligibility prior to your appointment; however, verification of eligibility is only done as a courtesy to you, and is NOT a guarantee of payment. As insurance companies do not guarantee an exact amount of payment until they receive a claim, we can only provide you with our best estimate of coverage based upon the information we have at the time of verification. Usually there are co-payments, eyeglass extras (for frames and lens options), contact lens services/materials and special tests/procedures that can exceed plan limits. We will contact you regarding any necessary adjustments, and either request additional payment or issue a refund as appropriate. Please check with your plan administrator if you have any questions regarding your policy details.

Please note that all payments for eyeglasses and/or contact lenses are due at the time the order is placed. All charges incurred are the patient's responsibility (as guarantor of payment) as of the date services are rendered, regardless of insurance status. Account balances older than 90 days will be subject to collections and/or legal action.

My signature below verifies that I understand and agree to the financial policy.

_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE**

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