

Michael J. Flohr, M.D.
& Associates



Hastings (269) 945-3866
Ionia (616) 522-1000
Lowell (616) 897-7000

www.AdvEyecare.net

How did you hear about our Office? Is there someone we may thank? _____

Please Print:

Today's date: _____

Name: _____ Mr, Mrs, Ms, Miss, Rev, Dr Sex: M F
First Middle Last (circle one)

Patient's Social Security # _____ - _____ - _____ Date of Birth ____-____-____ Status S M D W

Mailing address: _____
Street Apt# PO Box City State Zip code

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email: _____

Patient Employer: _____ Phone _____

Employer address: _____
Street City State Zip code

Guarantor

(Person responsible for bill if other than patient) _____ Phone _____ Relationship to patient _____

Guarantor's Employer: _____
Company Name Street City State Zip

Will this claim be covered under Workers Compensation? _____ Yes _____ No

If yes, Company name: _____ Authorized by _____ Phone: _____

Company Address: _____
Street City State Zip

In Case of emergency Contact or Secondary contact (person not living with patient)

Name: _____ Relationship: _____ Phone: _____

Address: _____
Street Apt# PO Box City State Zip code

Family Doctor: _____ Phone: _____

Address: _____
Street Apt# PO Box City State Zip code

Please take a moment to tell us how you use your eyes in your daily work and leisure activities. We Have many new lenses that are engineered to make specific activities more enjoyable through better and safer vision.

Use a computer: _____ hours per day, Reading Driving Golf Fishing

Hunting/Shooting Piano/Music Biking Boating Swimming Scuba Needlepoint/Knitting

Mechanical/Crafts Running Yard work Tennis Collecting Other

Hobbies: _____

Medical Insurance Information

(if you need Prior Authorization from your family physician, please obtain it prior to your visit)

Primary Insurance Carrier _____ Policy # _____ Group# _____

Policy Holder's Name: _____ Social Security # _____ - _____ - _____ Date of Birth ____ - ____ - ____

Policy Holder's Employer or Retiree's former employer: _____

Secondary Insurance Carrier _____ Policy # _____ Group# _____

Policy Holder's Name: _____ Social Security # _____ - _____ - _____ Date of Birth ____ - ____ - ____

Policy Holder's Employer or Retiree's former employer: _____

Vision Insurance Carrier _____ Policy # _____ Group# _____

Policy Holder's Name: _____ Social Security # _____ - _____ - _____ Date of Birth ____ - ____ - ____

Policy Holder's Employer or Retiree's former employer: _____

Do you have a Flexible Spending account or Health Savings Account: YES NO

Financial Policy

It is the policy of Advanced Eyecare Professionals to require **PAYMENT AT TIME THE SERVICES ARE PROVIDED**. By signing below I am stating that I understand this policy.

I understand that in the event of a returned product, Advanced Eyecare Professionals may charge a restocking fee, that will vary based on the companies expenses/costs. If my account balance remains unpaid after receiving a 60 day statement, I will be responsible for that balance plus an additional 1.5% monthly interest on the amount due. However, if the small balance on my account is under \$25 I should only expect to receive a statement every 6 months.

Remember that insurance is a form of reimbursement made on behalf of the patient to the doctor for service rendered and **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 know what your insurance pays and to pay any deductible amount, co-insurance or any other balance not paid for by your insurance.***

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to: Advanced Eyecare Professionals 915 West Green St. Suite 101 Hastings MI, 49058 or If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows: Advanced Eyecare Professionals 915 West Green St. Suite 101 Hastings MI, 49058.

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. Any products returned to Advanced Eyecare Professionals maybe assessed a restocking fee.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of my patient records, as per HIPPA policy.

I hereby assign all medical and or surgical benefits, to include major-medical benefits to which I am entitled including Medicare, private insurance and other health plans to **Advanced Eyecare Professionals**. I also authorize the Doctor to deposit checks received on Patient's account when made out to the Patient.

This assignment will remain in effect until revoked by me in writing. A photo copy 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 understand that I am responsible for all services not covered by insurance plans. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient/Parent or Guardian Signature: _____ Date _____