PAYMENTS

WE ACCEPT CASH, CHECK, VISA, DISCOVER AND MASTERCARD. ALL MEDICARE AND BLUE CROSS CHARGES ARE FILED FOR YOU. MEDICARE AND BLUE CROSS WILL PAY THE DOCTOR DIRECTLY. SOME COMMERCIAL CARRIER INSURANCE MAY PAY THE PATIENT DIRECTLY. THE PATIENT IS ULTIMATELY RESPONSIBLE FOR PAYMENT OF ANY MONEYS OR SERVICE DEEMED NOT COVERED BY THEIR INSURANCE CARRIER. ALL CO-PAYS, DEDUCTIBLES, PHARMACEUTICALS, AND CONTACT LENSES ARE PAYABLE ON THE DAY OF YOUR VISIT OR AT THE TIME THEY ARE DISPENSED. IN THE EVENT THE ACCOUNT IS NOT PAID IN FULL, THE UNDERSIGNED WILL BE LIABLE FOR COLLECTION COSTS, ATTORNEY’S FEES, COURT COSTS, AND HEREBY WAIVE ALL RIGHTS OF EXEMPTION UNDER THE CONSTITUTION AND LAWS OF THE STATE OF ALABAMA

NOT-COVERED ROUTINE SERVICE POLICY

AS YOUR PHYSICIAN, I WANT TO PROVIDE YOU THE BEST CARE POSSIBLE. THERE MAY BE CERTAIN SERVICES THAT I FEEL ARE NECESSARY FOR THE MAINTENANCE OF GOOD HEALTH THAT ARE NOT COVERED BY YOUR MEDICARE OR BLUE CROSS CONTRACT, OR OTHER COMMERCIAL CARRIER INSURANCE. WE WILL BE HAPPY TO FILE THESE CHARGES WITH YOUR INSURANCE, AT YOUR REQUEST, BUT YOU WILL BE EXPECTED TO PAY FOR THESE SERVICES IN FULL AT THE TIME THEY ARE RENDERED.

EXAMPLES ARE:
A. ROUTINE EYE EXAMS
B. NON-THERAPEUTIC CONTACT LENS
C. COLOR VISION TESTS
D. CONTACT LENS FITTINGS
E. CONTRAST SENSITIVITY TESTING

LET ME ASSURE YOU THAT I WILL ONLY ORDER WHAT I FEEL IS NECESSARY FOR YOUR TREATMENT AND CARE.

I HAVE READ YOUR POLICY AND AGREE TO PAY FOR SERVICES NOT COVERED BY MY CONTRACT AS I INDICATED BY MY SIGNATURE BELOW.

_____________________________    ________________________________
DATE                                      PATIENT SIGNATURE
NOTICE OF PRIVACY POLICY OF
ROSWELL R. PFISTER, M.D.P.C
d/b/a/ Pfister Vision C orrection Center
Drs. Pfister, Alvarez

This notice describes how medical information concerning you may be used and disclosed. It also explains how you can get access to this information. Please review it carefully.

We will not release your medical or financial information to anyone without your written permission with the following exceptions:

Information about you with your permission has to be released to:

1. To lawyers or courts in response to a subpoena. By law, we must comply.
2. To your insurance company or other payers of your medical expenses.
3. To other healthcare providers who are taking care of you or are performing tests on you.
4. To family members or friend who are involved in your care, unless you specifically request not to do so.
5. To healthcare analysts or for research for the purpose of improving the quality of care for all patients we serve. In this case, all information which identifies you as the person will be removed.

All electronic transmission will be done in a secure manner, always encrypted software.

You have the right to inspect and copy your medical and financial records at a reasonable time and at reasonable copy costs. If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend it.

If you believe your privacy rights have been violated, you may file a complaint in writing to our privacy officer, Clint Parkinson, at this office.

Federal regulation requires that we obtain your signature that you have read and agree with this policy.

_________________________________________    ________________
S i g n a t u r e    D a t e

I have read and wish to make the following changes in this policy.

_________________________________________    ________________
S i g n a t u r e    D a t e
NAME:______________________________________ DOB:_______________ AGE:__________
Address__________________________________ City______________ State ____ Zip______
Home #:____________________ Work #____________________ Cell#__________________
Email________________________ Can we email or text a confirmation for appointments? Y/N
SSN __________________ Referred by_________________ Occupation_________________
Your Physicians Name________________________ Date of Last Exam___________

PHYSICAL PROBLEMS:                     MEDICATION TAKEN:
________________________________________            ___________________________
________________________________________            ___________________________
________________________________________            ___________________________
________________________________________            ___________________________

MEDICINE OR OTHER ALLERGIES: ______________________________________________

GENERAL HEALTH:
CHECK IF YOU HAVE OR HAVE HAD:
___HIGH BLOOD PRESSURE ___EYE DISEASE ___DIABETES ___SINUSITIS ___DIZZINESS
___EYE INJURY ___MIGRAINES ___EYE SURGERY ___EPILEPSY ___GLAUCOMA
___HEART PROBLEMS ___DOUBLE VISION ___CROSSED EYES ___TUNNEL VISION
___ TEMPORARY LOSS OF VISION ___ OTHER _____________________

DO YOU SMOKE? Y/N   PACKS PER DAY ______
ALCOHOL CONSUMPTION ___WINE ___BEER ___ ALCOHOL ___X DAYS

CHECK IF ANY OF YOUR BLOOD RELATIVES HAVE OR HAVE HAD
___HEART DISEASE ___HIGH BLOOD PRESSURE ___DIABETES ___CANCER ___LUNG DISEASE
___THYROID ___CATARACTS ___GLAUCOMA ___LAZY EYE ___CROSSED EYE ___BLINDNESS

EYE DOCTOR'S NAME: __________________________ DATE OF LAST EXAM___________
YOUR MAIN VISUAL COMPLAINT/ PROBLEM
________________________________________________________________________

EYE PROBLEMS:                                                    EYEDROPS TAKEN:
___________________________________           ____________________________________
___________________________________           ____________________________________
___________________________________           ____________________________________
___________________________________           ____________________________________

CHECK IF YOUR EYES ARE BOTHERING YOU IN THE FOLLOWING WAYS:
___DOUBLE VISION ___FLOATERS ___LIGHT SENSITIVITY ___NIGHT VISION ___BURN ___DRY
___BLUR ___GRITINESS ___FLASHING ___ACHE ___HALO ___ITCH ___REDNESS ___TEARING
___HEADACHES
DO YOU WEAR CONTACT LENS? Y/N SOLUTION USED______________________________
FILLED BY WHOM?__________________________________________________________
ARE YOU INTERESTED IN CONTACTS? Y/N
ARE YOU INTERESTED IN REFRACTIVE SURGERY? Y/N

PATIENT'S SIGNATURE OR PARENT/GUARDIAN         DATE             DOCTOR'S SIGNATURE
NAME________________________________________DATE________________
ADDRESS________________________________________CITY_________________________
STATE ____ ZIP_______ HOME PHONE (___)_____________
CELL (___)__________________
EMPLOYER________________________ WORK PHONE (___)_____________
DATE OF BIRTH______________ AGE_____ SEX_______ SS# ________________
EMAIL________________________________________________

EMERGENCY CONTACT_______________________________
RELATION______________ TEL#________________________

NAME OF RESPONSIBLE PARTY______________________________________________
ADDRESS OF RESPONSIBLE PARTY:
________________________________________________________________________
CITY __________________ STATE____ ZIP________
RELATIONSHIP TO PATIENT ______________ BIRTHDATE_____________________

WERE YOU INJURED ON THE JOB? NO YES
DATE INJURED_____________________________

PRIMARY INSURANCE COMPANY
________________________________________________
CONTRACT #_________________________ GROUP #___________________
SECONDARY INSURANCE COMPANY
NAME________________________________________
CONTRACT#_________________________ GROUP#__________________

PATIENT OR AUTHORIZED PERSON'S SIGNATURE: I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW: I FURTHER AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDER SIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW.

____________________________________________
DATE

____________________________________________
PATIENT SIGNATURE