

New Patient Information

Name (First, M.I., Last): _____

Date of Birth: _____ Sex: Male/Female Marital Status: S M W D

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Social Security Number: _____

How did you hear about our office? _____

Employer: _____ Employer Phone: _____

Employer Address: _____

Primary Care Physician: _____ Phone: _____

Primary Insurance: _____ **Secondary Insurance:** _____

Policy Holder Name: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____ Policy Holder Date of Birth: _____

Policy Holder Social Security Number: _____
_____ Policy Holder Social Security Number:

Policy #: _____ Policy#: _____

Group Number: _____ Group Number: _____

Address: _____ Address: _____

Patient Name

Date

Amit R. Chokshi, M.D.
Office Financial Policy

Dear Patient:

Thank you for choosing Dr. Chokshi for your eye care needs. Our main concern is that you, our patient, receive the proper care needed to restore your health. We hope that you understand that our financial policy is necessary to maintain the vital health of our practice. Therefore, we have instituted the following policy. We ask that you read and sign our financial policy prior to seeing the doctor.

Payment for services is due at the time services are rendered. We accept cash, check, and for your convenience, Master Card/Visa/Discover/AMEX credit cards. We will be happy to process insurance as long as you provide us with your **most** current insurance card and accurate information for filing. We currently participate in Medicare and most managed care plans. If you are covered under an HMO policy, you must have a referral from your primary care physician in order to see our physician. For that reason, you must make sure that we are listed as providers under your insurance plan. We must emphasize the following:

1. Not all services are covered as benefits with all insurance companies. Any charges not paid by your insurance company are solely **YOUR RESPONSIBILITY**: such as refraction (the process of determining your eyeglass prescription) **\$40.00**. We will file your claim with your insurance company as a courtesy. It is not our obligation. If your insurance company does not pay your balance within 45 days, we ask that you contact your insurance company to help expedite payment to us.
2. If your insurance company does not pay in full within **60** days, we ask that you pay the balance due in cash, check, or credit card. Remember, ultimately you are the responsible party for services rendered.
3. Co-payments and deductibles are due at the time services are rendered. It is unlawful for us to waive co-pays or deductibles.
4. If you belong to an HMO or POS plan, you must have a referral form with you **each** and **every** time you arrive for an office visit. Some referrals may include several visits. If you do not obtain a referral, you are responsible for the payment, which is due at the time of service.
5. Returned checks will be subject to a **\$25.00** check fee.
6. All balances older than **90** days will be reviewed and turned over to our collection department for payment or will be sent directly to legal course for resolution. In the event of a defaulted account, you will be responsible for any collection and/or legal fees.
7. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate such problems to us so that we may assist you in the management of your account. Again, thank you for choosing us for your eye care needs. We appreciate the opportunity to serve you.
8. Due to the increase in no show appointments, there is now a **\$25.00** no show fee if you do not keep your appointment and did not give the office a 24 hour notice.
9. If you do not have a form of payment today for your office visit, you will be charged **\$10.00** for a billing processing fee.
10. If you have a change in your insurance and do not update it with the receptionist, you will be charged **\$20.00** to refile with your correct insurance.

Patient Signature: _____ Date: _____

By my signature, I indicate that I have read this policy and agree to its provisions.

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