Hanover Family Eyecare

For All Your Eyecare Needs

Patient Name: ________________________________ **DOB:** ________________________

Preferred Phone: H / W/ C _______________________

Patient Address: ____
Street *City* *State* *Zip*

Patient/Guardian Social: ___________________ **Guardian Name:** _____________________

Primary Insurance Member: ________________ **Primary Member DOB:** ______________

Relation to Primary Member: ❑Spouse ❑Child ❑Other __________________

Acknowledgement of Privacy Policies (HIPPA)

I acknowledge that I have been educated on and offered a copy of this office's Notice of Privacy Policies.

INIT: __________

Insurance Authorization

I request that payment of authorized insurance benefits for any services furnished to me, be made on my behalf to Hanover Family Eyecare, PLLC. I authorize Hanover Family Eyecare, PLLC to release any medical records about me to my insurance company that may aid in determining benefits or payment. **I understand that I am responsible for charges not paid by the insurance plan.**

INIT: __________

Advanced Beneficiary Notice (ABN)

Non-covered services: By signing below, I acknowledge I have been notified by my physician that the services identified may not be covered for reasons stated. I agree to be personally and fully responsible for payment. I understand that my doctor may order (more in-depth versions of) these tests if medically necessary.

Refraction (Process by which glasses and contact lenses are prescribed as part of a regular eye examination) **not considered medically necessary by Medicare and other medical insurance carriers** **Fee: $40.00**

INIT: __________

Patient/Guardian Signature: ______________________________ **Date:** ________________