

Donna B. Ornitz, M.D.  
**Pediatric Ophthalmology and Adult Strabismus**  
**Peninsula Eye Physicians**  
*Please Print Clearly and complete front and back*

Patient's first name		<b>Mother's Info</b>	<b>Father's Info</b>
Last Name		First Name	
Nickname		Last Name	
Date of Birth	M / F	Home phone	
Street Address		Daytime phone	
City, State, Zip		Cell Phone	
PCP/Pediatrician		Social Security #	
Referring Doctor		Employer	
Siblings seen in practice		Occupation	

Address:  
(If different from patient's)

Who may we thank for your referral? \_\_\_\_\_ Email: \_\_\_\_\_

**Medical Insurance Information**

Primary Medical Ins.		Secondary Medical Ins	
ID Number		ID Number	
Group Number		Group Number	
Who is the subscriber?		Who is the subscriber?	
Subscriber's birth date		Subscriber's birth date	
Employer		Employer	

**Vision Insurance Information( Standard VSP Plan Only)**

Primary Vision Ins.		Secondary Vision Ins.	
ID Number		ID Number	
Group Number		Group Number	
Who is the subscriber?		Who is the subscriber?	
Subscriber's birth date		Subscriber's birth date	
Employer		Employer	

**Financial Policy**

We will gladly bill your insurance for services rendered, we do this as a courtesy to our patients. However, to do so, we must have all insurance information provided to us before services rendered or payment in full is required. We will not become involved in disputes between you and your insurance company regarding eligibility, deductibles, co-payments, covered charges, etc., other than supply factual information as necessary. **It is crucial you are aware of your insurance benefits.** If your services are denied due to being a "non-covered benefit", or medical necessity, time restrictions or failure to get a referral for your visit you are responsible for the timely payment of services.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Patient/or Parent (if minor) or guardian

\*\* I acknowledge receiving Peninsula Eye Physicians Privacy Notice. \_\_\_\_\_(initial)

\*\*I consent to allow Peninsula Eye Physicians to send recall postcards and to leave messages at my \_\_\_\_\_(circle)

Home	Y	N
Work	Y	N
Cell	Y	N

UPDATED \_\_\_\_\_  
 Revised 6/14/06

**Continued on next page**

## NON-COVERED SERVICE WAIVER

I have been informed by Peninsula Eye Physicians that the service today may not be covered by my insurance company for the following reasons:

- Refraction** – A refraction is done to determine whether you are nearsighted, farsighted or have astigmatism. This is a very important part of a complete eye examination, especially in children who may have amblyopia(lazy eye), strabismus(crossed eyes), who are less than 5 years old, or who have failed a vision screening examination. Most importantly, it will determine how well you see and if you need glasses or other treatment. **Please be aware that your insurance company may not cover the refraction. Our charge for the refraction is \$50.00, which will be billed to you accordingly.** If you have Vision Service Plan (VSP) this charge may be covered. Vision insurance is strictly designed to cover basic eye examinations for refractive errors such as myopia-nearsighted, hyperopia-far-sighted, astigmatism. Medical insurance is designed to cover medical eye conditions (amblyopia, strabismus, cataracts, glaucoma etc. **(Please see a copy of the AAPOS policy statement at the front desk for further explanation regarding refractions in children.)**

\_\_\_\_\_ **I do want the refraction**                      \_\_\_\_\_ **I do not want the refraction**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

- I am not able to provide a current insurance card at this time. I now will be considered “self-pay” and I will pay the full amount of my visit today. I understand that Peninsula Eye Physicians **will not** do retro-active billing for services rendered.

- I do not have a valid referral or authorization from my insurance company. I now will be considered “self-pay” and I will pay the full amount of my visit today. I understand that Peninsula Eye Physicians **will not** do retro-active billing for services rendered.

## PHOTO RELEASE

I consent to have a photograph(s) taken of myself/my child \_\_\_\_\_ to be used for documentation or educational purposes.

**Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_