CLARIS
eye care & surgery
Phone: 952-522-4900
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Keith H. Carlson, M.D.
14101 Fairview Dr, Ste 350
Burnsville, MN 55337
info@clariseyecare.com

PATIENT REGISTRATION FORM

Patient Name: _____ Date of Birth: _____

Agreement of Financial Responsibility

Thank you for choosing Claris Eye Care & Surgery and Dr. Keith Carlson as your health care provider. We are committed to providing quality service to all our patients. The following is a statement of our financial policy, which we require that you read and understand prior to any treatment or services.

Insurance Benefits: Your insurance coverage is a contract between you and your insurance company. You are responsible for knowing your insurance benefits, including whether **Claris Eye Care & Surgery** is a contracted provider with your insurance, your covered benefits and any such exclusions, and any pre-authorization requirements. It is not the responsibility of Dr. Keith Carlson or Claris Eye Care & Surgery to know your insurance coverage.

Insurance Information: You are responsible for making sure **Claris Eye Care & Surgery** has up-to-date and accurate insurance information on file, including current insurance cards and/or changes in insurance policies. Failure to provide this information may result in charges being billed to you. Our staff ask that you update and verify your record at each visit.

Health Plan Deductibles, Co-Payments, and Coinsurance: It is your responsibility to know if your insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, or any other type of benefit limitation for the services you receive. You understand it is your responsibility to cover any additional charges as stated by your insurance policy or plan.

Physician Referrals: It is your responsibility to know if **Claris Eye Care & Surgery** is a contracted in-network provider recognized by your insurance company or plan or it may result in claims being denied or higher out of pocket expenses to you. It is your responsibility to know if your primary care provider's (PCP) referral requests have been processed and approved by your insurance company or plan. If claims are denied because the physician was not authorized, you will be responsible for full payment(s).

Self-Pay: If you do not have health insurance, are with an insurance plan that Claris Eye Care & Surgery is not contracted with, or you are unable to verify your coverage on the date of service, Claris Eye Care & Surgery will collect an estimated payment at the time of service. There may be additional charges depending on the services provided for which you may be billed for later. You understand and agree to pay for these services accordingly.

Financial Responsibility: You assume financial responsibility and will make full payment(s) if your insurance company denies coverage and/or payment for services provided, including but not limited to diagnostic testing which may not be considered medically necessary to your insurance plan. We will do our best to verify coverage, but it ultimately is your responsibility to know your benefits prior to being seen.

I hereby authorize payment of medical benefits directly to Claris Eye Care & Surgery for services rendered. Authorization is hereby granted of my medical record to my insurance company or its employees/agents as may be necessary to process and complete my medical claim(s). I further understand should my account become delinquent, I shall pay the reasonable collection expenses, if any. The duration of this authorization is indefinite and continues until revoked in writing.

I have read and consent to the financial policies contained above. My signature below serves as acknowledgement of a clear understanding of my financial responsibility.

Signature of Patient or Legal Representative: _____Date: _____

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Routine vs. Medical Eye Exam

Routine Eye Exam	Medical Eye Exam
Routine eye exam coverage is designed to pay toward a comprehensive eye exam that looks for but finds no medical problems.	Medical insurance pays toward eye exams that are medical in nature. Examples of medical visits include: • Eye Infection • Floaters • Dry Eyes • Loss of Vision • Cataract • Diabetes • Eyelid stye • Glaucoma
Routine coverage often pays for the exam and an eyeglasses prescription. Please call the number on the back of your insurance card for your specific coverage details.	When there is a medical diagnosis that Dr. Carlson finds, is following or is treating such as diabetes, cataracts or other examples listed above, we are REQUIRED to submit the exam as medical, not routine. In most cases a comprehensive exam that is medical in nature does not pay for an eyeglass prescription. Deductible and coinsurance apply.

I understand that how my visit is submitted to my insurance carrier will depend not only upon what I tell Dr. Carlson but also what he finds upon examination. I understand I am responsible for resulting fees as determined by my insurance carrier.

Patient Initials_____

Patient Personal Email Use

I consent to the use of email correspondence for appointment and/or surgery reminders and confirmations and for the use of the patient portal for your electronic medical records if you so choose. Occasionally, Claris Eye Care will email updates about services we provide but will contain no protected health information. You have the right to opt out at any time by calling our office.

Patient Initials_____

Protected Health Information (HIPAA)

I consent to the use and disclosure of my protected health information by Claris Eye Care & Surgery, Dr. Keith Carlson and staff for the purposes of treatment, payment and health care operations only.

I understand health care operations may include, among others, uses or disclosures relative to quality review, utilization review, medical necessity, or legal review. Protected health information may include medical records, insurance and payment information and other information used in whole or in part, to make decisions about me. I understand that information about how my protected health information may be used, along with the complete Notice of Privacy Practices is available and that I may request a copy at any time.

I understand that all information is used in the care and treatment of my condition. No information, medical or otherwise shall be used for commercial purposes or released to any party for purposes other than my healthcare.

I also authorize the release of my information to: _____ Relationship_____

Phone_____

Signature of Patient or Legal Representative: _____Date: _____

Name of Legal Representative Completing Form on Behalf of Patient: _____