Registration : Jack E Abrams MD PC

Date	Account ID	Chart ID	Other ID	Internal Use

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #

Address	Home:	How did you hear of us?
	Work:	
Address 2	Cell:	
	Email:	

City	State	Zip Code	Employer Name & Address	Occupation

Emergency Contact	Phone	Pharmacy	Pharmacy Phone

Physician **Family Physician** **Referring Physician**

Medical Insurance	Name & Address	Policyholder	Relationship	Copay	Policy ID	Group ID
1						
2						
3						

Guarantor (Person to be billed, if different than patient)

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:

City	State	Zip Code	Employer Name & Address	Occupation

2. Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work:	Email:

City	State	Zip Code	Employer Name & Address	Occupation

HIPAA Approved Contacts

1. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work:

2. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work:

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to Jack E Abrams MD PC , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	Signature Date
X	

Jack E Abrams MD PC
6450 Medical Center St, Suite 100
Las Vegas, NV 89148
Phone: 702-304-9494
Email:

Please attach all pertinent insurance ID cards for photocopying.

Abrams Eye Institute

Authorization to release Medical Records

I hereby authorize my physician(s) and Jack Abrams, MD/Tapan Shah, MD to release any information acquired in the course of my treatment to authorized representative or entities to support claims for services or materials rendered.

This assignment and authorization shall be binding upon my heirs, executors and administrators.

_____ _____

Patient Signature (parent/Guardian Signature) Date

_____

Office Representative Initials

Refraction Fee Policy – For Eyeglasses

Refraction is the process of determining the eye's refractive error, or need for corrective glasses. We will only perform this procedure if you have a need for glasses. The cost for a prescription for glasses is **$45.00.**

Most medical insurances do not cover the cost of the refraction test because it is considered a **VISION** test. At Abrams Eye Institute we are a Medical Specialty Ophthalmology Practice and do not bill for vision services.

☐ Yes, I want to have a refraction test performed today and understand I am responsible for the $45.00 Fee.

☐ No, I do not want a refraction test performed today

_____ _____

Patient Signature (parent/Guardian Signature) Date

PLEASE NOTE: *Once dilated, we will not be able to perform refraction test and you will need to schedule another visit for the refraction.*

Health Insurance Benefits/Coverage/ Authorization Disclaimer

As a courtesy, Abrams Eye Institute will attempt to verify your medical health insurance benefits and or necessary authorization. Please be aware this is only "A Quote of Benefits/Authorizations." **We cannot guarantee payments or verify that definite eligibility of benefits conveyed to us or to you by your carrier will be accurate or complete. Payment of benefits are subject to all terms, conditions, limitations and exclusions of the plan at the time of service.**

Please note: It is your responsibility to know your insurance benefits. At the time you become a participating member of your insurance company, you are given a handbook and ID card. Every effort will be made by this office to have all service and procedures preauthorized by your health insurance company. Your insurance company will pay for services that are deemed "reasonable and medically necessary." If denied or deemed a non-covered benefit the balance becomes patient responsibility.

Abrams Eye Institute Policy

Co-pays, co-insurance, deductibles and non-covered services cannot be waived by our office, as it is a requirement placed on you by your insurance carrier. Failure to pay your portion of services rendered will be reported to your insurance company and could result in termination of your insurance plan. The Patient is responsible for all fees, regardless of insurance coverage. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due to the doctor. A copy of the signature is as valid as the original. If you are unable to pay at the time of service your appointment may be rescheduled.

(Signature)_____

Insurance Reimbursement

I understand that all monies collected at the time of service is an estimated quote with information my insurance provides to Abrams Eye Institute. ***(Initial)***_____

I understand that once claims are processed, if I am left with a higher responsibility than what was quoted to me, I will be billed for the remainder and I am required to pay balance due within 30 days of notification unless other financial arrangements have been made. ***(Initial)***_____

Insurance Disclaimer: "A quote of benefits and/or authorization does not guarantee of payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations and exclusions of the member's contract at time of service."

_____ _____

Patient Signature (Parent or Guardian Signature) Date

_____ _____

Print Name Office Representative

Abrams Eye Institute

Jack Abrams, MD • Tapan Shah, MD • Christopher DePalo, DO

6450 Medical Center Street, Suite 100 • Las Vegas, Nevada 89148 • Office: 702-304-9494 • Fax: 702-304-9495
1470 E. Calvada Blvd, Suite 300 • Pahrump, Nevada 89048 • Office: 775-537-2020
2451 W. Horizon Ridge Pkwy, Suite 130 • Henderson, Nevada 89052

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will allow another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to other people.

Office appointments cancelled with less than 24 hours notification may be subject to a **$25.00** cancellation fee. Procedure cancellations require 3 business day advance notice, without notification they will be subject to a **$25.00** cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as "**NO SHOW"**. Patients who "No-Show" three (3) or more times in a 12 month period, may be dismissed from the practice; thus they will be denied any future appointments. Patients may also be subject to **a $25.00 fee for office appointment "No Show" and $25.00 procedure "No Show" fee.**

The "Cancellation" and "No Show" fees are the **sole responsibility** of the patient. This fee is **not covered** by insurance, and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but **only with management approval**.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department (702-389-5862).

Please sign that you *have read, understand and agree* to this Cancellation and No show Policy.

_____ _____

Patient Name (Please Print) **Date of birth**

_____ _____

Signature **Date**