Belle Vue
SPECIALTY EYE CARE

7127 Highway 98, Suite 30, Hattiesburg, MS 39402
Phone: 601-475-2020 **Fax:** 800-493-5956 **Email:** hello@bellevuesec.com

BASIC PERSONAL INFORMATION

How We May Contact You

Some forms of communication are not compliant with HIPPA standards, please mark any/all ways you would like to be contacted:

- ☐ Phone ______________________________
- ☐ Text Message
- ☐ Email ______________________________
- ☐ All of the above

Insurance Details

Name of Insurance:

____

Patient's Name as Listed on Card:

____

Member ID: ______________________________

Medicare Patients

We are an opt-out provider. You cannot submit a calim to Medicare to reimburse you for your visits, services or supplements. Initial here: ______

Agreement to Pay

- ☐ I understand and agree that I am responsible for payment at the time of my appointment including phone consults, services or when purchasing supplements.

We accept cash, debit cards, checks, VISA, MasterCard and Care Credit. Should your check be returned for insufficient funds, you will be charged a $25 NSF fee and you will need to pay with cash or a credit card. Patients are responsible for all costs associated with collections on their accounts.

Medicaid

If a service rendered is deemed a non-covered service by your provider you will be billed for these services. Initial here: ______

RightEye System

We utilize the RightEye System for eye tracking and information such as name, date of birth, previous brain injuries, and dominant hand is required. If you consent for this information initial here: ______

Acknowledgement of Notice of Privacy Practices

The law requires that Belle Vue Specialty Eye Care make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ **I have read or had explained to me Belle Vue Specialty Eye Care's Notice of Privacy Practice and agree to continue my care with Belle Vue Specialty Eye Care under said terms.**
- ☐ I was given the opportunity to read Belle Vue Specialty Eye Care's Notice of Privacy Practices and **declined but wish to continue** my care with Belle Vue Specialty Eye Care under the terms of Belle Vue Specialty Eye Care's privacy policies.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient: ______________________________

Date: ________/________/________

If you are signing as a personal representative of the patient, please indicate your relationship:

Representative: ______________________________

Relationship to Patient: ______________________________