Welcome to J. Micetich OD & Associates
Family Eye Care

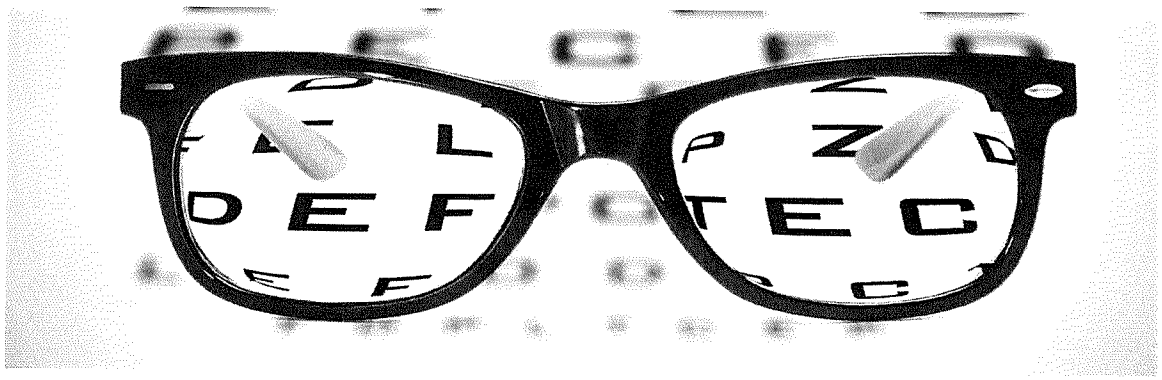
We have updated our computer system and all paper work needs to be filled out. We also need updated medical and vision cards.

Insurance info: We do not take HMO plans without a referral. You must call and get a referral from your primary care doctor 1st.

We do book fast so to get an appointment around the same day and time next year its best we pre appoint you. We will remind you of your upcoming appointment with your preferred method of communication. Please let us know if you want to be pre appointed or not.

___ Yes, pre-appoint me for my annual eye exam.

___ No, do not pre-appoint me for my annual exam. I will call to schedule this myself.



Step 1:** ***Please completely fill out forms and return to receptionest with both medical and vision insurance cards.

Patient Name: _____

Street Address:_____

City:_____

State:_____Zip:_____

DOB: _____/ _____/ _____ SS#_____

If primary phone number is a cell you will get text reminders. If primary phone is a home number you will get a voice recording.

Primary Phone: _____cell or home

2nd Phone:_____ cell or home

*Step 2:

E-Mail address:_____

May we e mail you? Yes or No

*Step 3:

*****Please bring up ALL medical and vision insurance cards so we can update the system.*****

Responsible Party info:

Name: _____

Street Address:_____

City:_____ Phone #: _____

State:_____Zip:_____

DOB: _____/ _____/ _____ SS#_____

J Micetich OD & Associates Family Eye Care Center
20 E. North Street, Coal City, IL 60416
Phone: 815-634-4825
Fax: 815-634-4938

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office or from our Web site.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. By signing, you signify that you have no other health or vision insurance (or that you have provided us all insurance information) and agree that, since there is no guarantee of payment by an insurance company, you will be responsible for payment for services received in our office should the insurance not pay. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

_____ _____

Dated Signature of Patient

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

_____ _____

Relationship to Patient Print Name

Is there anyone else with whom we can share your information with in your absence?

_____ _____ _____

Print Name Telephone Number Relationship to Patient

J. MICETICH, O.D. & ASSOCIATES

FAMILY EYE CARE CENTER

Contact Lens Fitting and Evaluation Agreement

The contact lens evaluation is an additional fee NOT included in your comprehensive eye exam. The price for this extra service depends on the type of lens and complexity of the contact lens fit determined by the doctor for your visual needs. This fee includes the initial visit, insertion/removal training if needed, and follow up visits. We do require these charges paid at the time of the fitting and they are non-refundable.

Contact lens evaluation fees can range up to $105.
Prices may be lower with vision insurances that contribute to contact lens evaluations. Co-pays are determined by your insurance company.

Contact lenses require an evaluation yearly as they are a medical device on your eyes in order to maintain proper ocular health and vision with your lenses.

I have read and understand the above information in this agreement. I also acknowledge that I have had all my questions answered.

_____

Signature of patient or legal guardian Date

_____

Print name

Jonathan Micetich, O.D. **Nicholas Rutkowski, O.D.** **Jennifer Chu, O.D.**

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