



Mark G. Mitchell, O.D.

WELCOME TO THE OFFICE OF DR. MITCHELL

Please Complete BOTH Sides

Mr. Mrs. Ms. Dr. Full Name Nickname Date

Street Address Mailing Address
City State Zip

Home Phone Work # E-mail Address

Date of Birth Age Sex M F Social Security #

Spouse (or Parents) Name Spouse (or Parents) Work #

Your Employer or School Occupation

Vision Insurance Health Insurance

Name of Insured Date of birth Relationship to Patient

Primary Care Physician Phone number

Who May We Thank for Referring You?

- If not referred, how did you choose our office?
Another doctor Saw sign Insurance List Newspaper
Web Referral Which Website?
Other

When was your last eye exam? Which Doctor?

Reason for your visit today?

Circle any Conditions that Apply to You:

- Distance Blur Cataracts Crossed Eyes Light Sensitivity Dry Eye
Near Blur Glaucoma Lazy Eye Burning/Redness Tearing Eyes
Floaters Eye Injury Patching Headaches Itching Eyes
Flashing Lights Double Vision Vision Therapy

Eye Diseases Drug Allergies

Eye Surgery Other

Is there a history of any eye disease in your family?

Continue on reverse...

Mark G. Mitchell, OD

4600 Kietzke B-119
Reno, NV 89502
775-825-0506

150 Pacific Suite 1
Portola, CA 96122
530-832-0202

Financial Policy

Payment terms

Payment for services not covered by insurance is required at the time of service. A 50% deposit is needed to start an eyeglass order. Contact lens orders must be paid in full before ordering.

If we do not participate in your insurance plan, **you** are responsible for filling out all insurance paperwork and submitting your insurance claim. We will provide a receipt to include with your claim.

We accept cash, checks, Visa and Mastercard. We cannot accept post-dated checks.

There is a \$30 fee for any returned check.

Insurance

If we are providers for your insurance, we will bill the insurance **one time**. If we have not received payment from your insurance within 60 days, you are responsible for the entire amount of the bill

If you have Medicare and a secondary insurance, we will bill the secondary insurance company one time. If we have not received payment within 60 days of submitting the secondary insurance claim, then you are responsible for the balance.

If your insurance does not pay your bill or you disagree with the amount they covered you must contact the insurance company directly to find out why. Our office has no explanation of your benefit coverage. Only your insurance company can provide you with those details.

If we cannot get an insurance authorization at the time of service, you may pay for services and submit the insurance claim yourself. Or, we will allow you to reschedule your appointment one time to allow you to contact your insurance company or your employer’s human resource department yourself to check your coverage.

Billing

For balances due for services, we will send TWO statements and a final reminder letter as a courtesy.

After the first statement, there is a \$10 monthly billing fee that will be added to unpaid balances.

You have 60 days from the date of the first statement to pay your balance. After 60 days, the amount will be sent to our collection agency.

If you have a question about your statement that is not related to your insurance, please contact Sheri, our office manager at (775) 825-0506.

Prescription Orders

We will hold eyeglass orders for 30 days after they have been completed. If you do not pick up your glasses after 30 days, the order will be canceled, and a 50% cancellation fee will apply.

If you choose to use your existing frame, you are aware that you cannot hold our office or the Lab responsible if the frames break during lens insertion or subsequent adjustment. If your frame breaks during processing or adjusting, you will be responsible for paying for repairs or purchase of a new frame and lenses.

Your purchase of NEW frames is covered under warranty for a period of ONE YEAR against manufacturer defects. They will not be covered for misuse or abuse of any type.

Polycarbonate lenses are covered one time for a period of ONE YEAR against scratches or breakage. They are not be covered for misuse or abuse of any type. Regular glass or plastic lenses are not covered against breakage or scratches.

Opened boxes of disposable contact lenses cannot be returned for credit or refund.

Appointments

If you cancel or reschedule your appointment with less than 24 hours notice, or arrive 10 or more minutes late for any scheduled appointment you will be charged a cancellation fee of \$51

Patient Records will be retained by our office for a period of 5 years.

I have read and understand the practice’s financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of Patient, Parent or Legal Guardian

Date