Dan Boespflug, O.D. ● Chad Cleverly, O.D. ● Justin Denison, O.D.
3293 N Milwaukee St ●Phone: 208-322-2020 ●Fax:208-322-1192

Patient Name: Click here to enter text.
Address: Click here to enter text.
City/State/Zip: Click here to enter text.
Home Phone: Click here to enter text.
Day Phone: Click here to enter text.
DOB: Click here to enter text.
SSN#: Click here to enter text.
Occupation: Click here to enter text.

Insurance: Click here to enter text.
Insurance ID: Click here to enter text.
Name of Primary Member on Insurance:
Click here to enter text.
Primary Member's DOB:
Click here to enter text.
Employer Name: Click here to enter text.
E-mail: Click here to enter text.

Communication Pref. for Appointments (check all that apply): ☐ E-mail ☐ Postal ☐ Telephone-Text
Sunglasses: Own ☐ Interested In ☐ Contact Lenses: Current Wearer ☐ Interested In ☐

- I acknowledge I have reviewed / been given the opportunity to review the **Notice of Privacy Practices**. (A copy available upon request.)
- I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services. I request that payment of authorized insurance benefits for any services furnished me, be made on my behalf to Boise Vision Care, P.A.
- Services are rendered and charged to the patient, not the insurance company. We are happy to file a claim for you, but we cannot accept responsibility for collecting or negotiating a settlement on a disputed claim. Fees not paid by your insurance company and insurance balances aged 45 days will be your responsibility. Unpaid patient balances aged 30 days or more will incur a minimum $3/maximum 3% monthly finance fee.
- Once an order is started by the lab, it cannot be canceled. The patient is responsible for the balance.
- Boise Vision Care has attempted to verify my benefits using information I provided. My insurance company does not guarantee any benefits to Boise Vision Care. I am responsible for knowing my benefits and selecting my healthcare provider, whether in or out-of-network.
- **Once an order is started by the lab, it cannot be canceled. The patient is responsible for the balance**

Notice of Non-Covered Services

- This notice is to inform you that your health plan may not cover the fee(s) listed for the following reason(s):
  - The service(s) are excluded under your plan.
  - Prior authorization is required and has not been received or has been denied.

  * Subject to insurance policy deductible, co-pay, or co-insurance

Refraction 92015 $39.00 - Retinal Screening 92250-52 $39.00 - Contact Eval 92310 $42.00
*Diabetic Retinal Screening 92250-52 $39.00 - *Medical Retinal Photo 92250 $108.00

By signing, I acknowledge that I have read and understand each statement and verify that all personal information is correct.

Adult Signature: ____ Date: ____________________

Relationship to Patient: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Other: ____________________