
FAQ's

Scheduling

Please call: voice **509-921-5706** [24 hrs] and leave a message
fax **509-921-5706** to fax information needed prior to exam.

Regular Examinations

Tuesday - Friday **9am - 6pm**
Saturday **10am - 4pm**
appointments for other times can be scheduled as needed

Emergencies and Urgencies

Please call **509-921-5706** and follow instruction for "emergencies".
For emergencies, the patient can be scheduled as soon as transportation can be arranged.

Location + Mailing Address

Services are provided at **Hope Eye Care PS**
200 N Mullan Rd, Suite 118
Spokane Valley WA 99206-6827

Please make sure the driver of the transportation knows to look for "Hope Eye Care PS, Suite 118"

Patient Information needed

Form to sign: **Signatures on File** (please make copies as needed of backside)
current: **Admission sheet** (face sheet)
Provider One Service Card (Medicaid if applicable)
doctor's orders: diagnosis + medications
blood sugar notations + HbA1c if patient is diabetic
for your records: Signed order by primary care physician
(for "optometric consultation and treatments as indicated")

Examination reports

A written examination report (if required by applicable rules/regulations), for the facilities records, will be supplied usually at the end of the examination if permitted by transport pickup, or within 7 days after examination. Prescriptions will usually be given right after examination.

Billing/Insurance

Accepted are assignments for most insurances, including Medicare and Medicaid, and claims will be submit directly. No additional paper work for your facility is involved.

In case the patient requires services, hardware (eyeglasses, contact lenses, low vision aids, etc), or repairs not fully covered by insurance, payment is expected at the time services are rendered, unless other arrangements are made in advance. Hardware will only be ordered once payment has been received. Additional forms may need to be completed prior to services rendered or hardware received, especially when Medicare, Medicaid or other insurance coverage is in effect.

Signatures on File

Patient Name: _____ SSN: _____

Assignment of Benefits

I request that payment under the medical insurance program be made to my provider on any bills for services furnished to me during the effective period of this authorization and I authorize the provider to release to the Social Security Administration, its intermediaries or carriers, any insurance company, and/or payor I am covered by any information needed for any claim submitted.

Authorization Period from _____ until revoked Initial: _____

Financial Responsibility

I understand that I am financially responsible for all services and/or hardware provided /dispensed and agree to pay promptly upon request for my bills as well as for any interest charged and/or costs incurred in collecting any unpaid balances. In case my insurance(s)/payer pays me directly instead of my provider, I promise to forward immediately to my provider any payments I might have received.

Initial: _____

Permission For Treatment

I hereby authorize the provider(s) and/or assistants for the care of the patient named on this record to administer any treatment as may be deemed necessary including examination or treatment that may be ordered to be performed by clinical personnel and review of all records of the facility I may reside in, if applicable. (As part of a complete eye examination and ocular health assessment diagnostic eye drops to dilate the pupils may be used. Your eyes will stay dilated for awhile. You might experience some blurring of your near vision and extra sensitivity to lights. It is recommended that you do NOT drive a vehicle while dilated and you agree to arrange for a driver when your eyes are dilated.) I am aware that the practice of optometry is not an exact science and I acknowledge that no guarantees have been made to me as the result of examination or treatments performed.

Initial: _____

Acknowledgement of Privacy Practices

I certify that I received/read a copy the Privacy Notice and that I have had an opportunity to review this document and ask questions to assist me in understanding my rights relative to the protection of my health information. I am satisfied with the explanations provided to me in protecting my health information.

Initial: _____

Signature

Signature: _____ Date: _____

I permit a copy of this form to be used in place of the original.

Please circle your relationship to the patient: Self Legal Guardian Power of Attorney

If you are not the patient and have signed this form please print your name below:
