



## PATIENT REGISTRATION INFORMATION

Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Gender:  Male  Female  
Address: \_\_\_\_\_ Apt#: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ (EMAIL AND PHONE ARE REQUIRED)  
Marital Status (circle one): Single/Married/Div./Sep./Widowed Spouse's Name (if applicable): \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Pharmacy Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Referred by: \_\_\_\_\_  
In case of emergency, who should we contact? \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
 Workman's Compensation: \_\_\_\_\_  No Fault: \_\_\_\_\_

### **PRIMARY INSURANCE:**

Person responsible for account: \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address (if different from patient): \_\_\_\_\_  
Ins. Company: \_\_\_\_\_ Ins. Company Address: \_\_\_\_\_  
Subscriber ID#: \_\_\_\_\_ Group #: \_\_\_\_\_ Co-pay: \$ \_\_\_\_\_

### **ADDITIONAL INSURANCE:**

Person responsible for account: \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address (if different from patient): \_\_\_\_\_  
Ins. Company: \_\_\_\_\_ Ins. Company Address: \_\_\_\_\_  
Subscriber ID#: \_\_\_\_\_ Group #: \_\_\_\_\_ Co-pay: \$ \_\_\_\_\_

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICAL INFORMATION SHEET**

**NAME:** \_\_\_\_\_

**Chief Complaint:** What is the main or primary problem with your eye(s), and when did you first notice symptoms or were you told of diagnosis?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**EYE History (Please circle all that apply) or circle NONE**

- |                           |                   |                      |
|---------------------------|-------------------|----------------------|
| Glaucoma                  | Cataract          | Lazy Eye (Amblyopia) |
| Crossed Eyes (Strabismus) |                   | Macular Degeneration |
| Retinal Detachment        | Eye Injury        | Eye Inflammation     |
| Laser Surgery             | Operative Surgery | Other: _____         |

**GENERAL HEALTH (Please circle all that apply) or circle NONE**

- |                             |             |                |                             |
|-----------------------------|-------------|----------------|-----------------------------|
| Fevers                      | Weight Loss | Fatigue        |                             |
| Sinusitis / Nasal Allergies |             | Hearing Loss   | Dry Mouth                   |
| Angina / Chest Pain         |             | Heart Attack   | Congestive Heart Disease    |
| Rheumatic Heart Disease     |             | Heart Murmur   | Irregular or Slow Heartbeat |
| High Blood Pressure         |             | Stroke         |                             |
| Shortness of Breath         | Asthma      | Bronchitis     | Emphysema                   |
| Heartburn / Ulcer           | Hepatitis   | Diabetes       |                             |
| Liver Disease               |             | Kidney Disease | Kidney Stones               |
| Other: _____                |             |                |                             |

**PAST MEDICAL HISTORY:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SURGICAL HISTORY:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Smoking History:**

*Do you Smoke:* Yes No  
*If Yes:* Are you trying to quit?  
Yes No  
*If No:* Are you a former smoker?  
Yes No

**FAMILY HISTORY (GENERAL OR EYE):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medications (Names/dosage):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies to Medications (Name/reaction):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please Answer if age >65**

Influenza vaccine: Yes No  
Pneumococcal vaccine: Yes No  
Shingles vaccine: Yes No

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Doctor's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Do you want anyone to have access to your medical record?**

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to Privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this practice has the right to change this notice from time to time, and that I may contact the practice at any time to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

The type of PHI to be restricted or limited:

\_\_\_\_\_

I give permission to discuss my medical care with the following individuals:

\_\_\_\_\_

I understand that I may revoke this consent at any time, except to the extent that you have to take action relying on this consent.

**Refraction & Contact lens fitting Fee Policy (MEDICAL PLANS)**

What is a refraction?

Refraction is a test done to determine the refractive error of your eyes, or the need for corrective glasses and/or contact lenses. i.e. A Glasses prescription.

When do I have to pay for a refraction?

Refraction (CPT code 92015) is a non-covered service by Medicare.

As a result, your healthcare provider is required by CMS (the department to the federal government that controls Medicare) to charge for this service. Most other insurance plans follow Medicare's rules. All these plans consider refraction a "vision" service not a "medical" service. If you have a separate vision plan please let us know.

How much do I have to pay?

You will only be charged a refraction fee if you receive a prescription for glasses or contact lenses. **Our office fee for refraction is \$50. Contact lens fitting costs vary.** This is collected at the time of service in addition to any copayment your plan may require. Should your plan pay us for the refraction, we will refund accordingly.

Patient's Name:

Signature of Patient:

Relationship to Patient:

Date:

## PATIENT FINANCIAL POLICY

**In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.**

- As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor, in other words you agree to have your insurance pay the doctor directly. If your insurance company does not pay the practice within a reasonable length of time, (within 45 days) you may be responsible.
- Your insurance policy is a contract between you and your insurance company, the doctor is not involved. We attempt to verify benefits ahead of any appointment but it is your responsibility to ensure benefits and status of policy.
- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. We will collect the co-payment at the time of the service. It is your responsibility to ensure if the provider is in network or out of network.
- If you fail to notify us of an insurance change, you are fully responsible for any amount not paid by your insurance company.
- If you have insurance coverage with a plan that we do not have a prior agreement we will prepare and send the claim for you. Therefore our charges or your care and treatment are due at the time of service.
- Unless either you or your health coverage carrier have made other arrangements in advance, full payment is due at the time of service. For your convenience we will accept VISA, MasterCard & Discover.
- **Please note** – Balances that are forwarded to a third party collection agency will be subject to a service fee of up to 30% of the overdue balance.
- If we receive a returned check from our bank for a payment you made, you will be invoiced for the original amount of the check plus a \$25 bank fee per check. The payment of the invoiced amount will be due within 10 days of invoice date.
- We will NOT re-submit the original declined check. All amounts remaining outstanding will incur interest and/or late fees as set forth on the invoice.
- Amount that remain outstanding for more than 60 days will be sent to a third party for collection.
- All plans are not the same and do not cover the same services. In the event your plan determines a service to be “not covered”, you will be responsible for the complete charge.
- Some plans require a referral (i.e HMO plans). It is your responsibility to obtain the referral for your services and to ensure it was received and correct. If a referral is not obtained or is not accurate you are responsible for any amount due.
- For all services provided by our physician(s) in the hospital, we will bill your plan. Any balance due is your responsibility.
- For all services rendered to minor patients, we will hold the parent or guardian accompanying the minor responsible for expenses incurred.
- As we offer services to you, and not products, we are unfortunately unable to offer refunds on any services performed.
- In order to provide the best possible service and availability to all our patients please call us as early as possible if you know you need to reschedule your appointment. There is a late cancellation fee (\$30)/ if you do not cancel or reschedule your appointment within 24 hours.

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

**I hereby state that I have listed ALL the INSURANCE COVERAGE and am aware of no other insurance(s). Otherwise, I am responsible for any claims not paid because of not informing this office of all medical coverages**

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Name

Date