



## PATIENT REGISTRATION INFORMATION

Today's Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_  
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Gender:  Male  Female Language(s) Preferred: \_\_\_\_\_  
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: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

**WORKMAN'S COMPENSATION CARRIER:** \_\_\_\_\_ Adjuster Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Claim # \_\_\_\_\_ DOI: \_\_\_\_\_

### **PRIMARY MEDICAL INSURANCE:**

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

### **SECONDARY MEDICAL INSURANCE:**

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

### **VISION INSURANCE:**

Insurance Company: \_\_\_\_\_ Person responsible for account: \_\_\_\_\_  
Subscriber ID#: \_\_\_\_\_ Subscriber SSN#: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address (if different from patient): \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Employer Telephone: \_\_\_\_\_

**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 medication: (Name/reaction):**

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

**Please Answer if age >65**

Please circle below  
Influenza vaccine: Yes No  
Pneumococcal vaccine: Yes No  
Shingles vaccine: Yes No

**Patient 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 (HIPAA), 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.

**Signature:**

**Date:**

\_\_\_\_\_

**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.

Patient's Name: \_\_\_\_\_

**Signature of Responsible Party:** \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

## PATIENT FINANCIAL POLICY

We are dedicated to providing the best possible care and service to you. We regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. If you have any questions about the policy, please ask one of our staff members for further clarification.

- Effective 1/1/2019, the only medical assistance insurance plans accepted here are: VA Medicaid, Anthem Healthkeepers Plus and Optima. If you have any other medical assistance program as a secondary to your primary insurance, you are responsible for any balance due.
- **PLEASE NOTE:** We no longer bill medical plans for refractions in accordance with CMS guidelines
- Full payment of patient responsibility is due at the time of service. 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 patient responsibility at the time of service.
- 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 time, but it is your responsibility to ensure benefits and the status of your policy. It is your responsibility to determine if the provider is in network or out of network. **If we are 'Not-in-Network' with your insurance, you will be responsible for all charges for the visit which will be due at the time of service.**
- 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 confirm the referral was received by our office and is correct. Referrals for appointments must be received at least 48 hours prior to the day of visit, otherwise the appointment will be cancelled. If a referral is not obtained or is not accurate, you are responsible for any amount due.
- As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor, which means you agree to have your insurance company 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.
- **PLEASE NOTE:** If you fail to notify us of an insurance change or accurate insurance information **PRIOR TO YOUR APPOINTMENT DATE**, you may be responsible for any amount not paid by your insurance company.
- **PLEASE NOTE:** If during a routine vision exam, the provider deems it necessary to perform additional medical tests then your medical insurance will be billed for these additional charges.
- For all services rendered to minor patients, we will hold the parent or guardian accompanying the minor responsible for expenses incurred. The parent or guardian must be present at the time of each appointment for the full duration of the visit.

### FEES:

- **PLEASE NOTE:** **There is a \$30 no-show fee for any in-office appointment not cancelled or rescheduled at least 48 hours prior to the schedule date.** If you reschedule and/or no-show more than 3 times, we will collect a deposit of \$50. There is a non-refundable \$300 no-show/cancellation fee for procedures/surgeries not cancelled at least 72 hours prior to the date of the procedure, if non-medical reasons apply.
- A fee of \$15 will be charged to obtain a copy of your medical records. A fee of \$25 will be charged for completion of medical forms (i.e., DMV vision forms). In certain instances, an office visit may be necessary to complete the forms in the office; otherwise please allow up to 7 business days for processing.
- We are unable to offer refunds or credits on visits, services performed or retail items. All sales are final.
- Refunds for credit card transactions may be subjected to a 3% deduction fee.
- Amounts that remain outstanding for more than 90 days will be sent to a third party for collection. Balances that are forwarded to a third-party collection agency will be subject to a service fee of up to 50% of the principal 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 \$35 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.

**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 my complete INSURANCE COVERAGE and am aware of no other insurance(s). I understand that I am responsible for any claims that are not paid due to negligence in informing this office of all insurance coverages.**

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