Advanced Eye Care Confidential Patient Information

Dr. Mr. Mrs. Ms. Miss _____ ___Male __Female D.O.B.:____/____/____ Age: _____

SS#:_____-_____-_____ Marital Status: Single ____Married ____Widowed ____Divorced ____ Spouse's Name: _____

Address:_____

HmPh:_____CellPh:_____TextingOk?_____Email:_____

Employer/School: _____ Occupation: _____

Primary Care Physician: _____ Date of Last Visit: _____ Pharmacy:_____

Referred by: Patient: _____ Doctor: _____ Other: _____

Parent/Legal Guardian ***or*** Emergency Contact:_____Primary Phone:_____

As a courtesy, we will file most insurance claims when you provide the following:

1. Photocopies of the front and back of your valid insurance ID card.
2. Authorization to file insurance claims and receive direct payment for services rendered.

Primary Medical Insurance: _____Policyholder: _____
Policyholder's D.O.B.: _____Policyholder's Social Security #_____Relationship to Patient:_____
Secondary Medical Insurance: _____Policyholder: _____
Policyholder's D.O.B.: _____Policyholder's Social Security #_____Relationship to Patient:_____
Vision Plan:_____Policyholder: _____
Policyholder's D.O.B.: _____Policyholder's Social Security #_____Relationship to Patient:_____

INFORMED CONSENT & TREATMENT AUTHORIZATION

The law requires that we make every effort to inform you of your rights related to your personal health information.

§ I have read or had explained to me the *Notice of Privacy Practices* for Advanced Eye Care and agree to continue my care with Advanced Eye Care under said terms.

§ I was given the opportunity but declined to read the *Notice of Privacy Practices,* for Advanced Eye Care but wish to continue my care with Advanced Eye Care under the terms of his privacy policies.

§ I have read or had explained the *Notice of Privacy Practices* for Advanced Eye Care and do not wish to continue my care with Advanced Eye Care under said terms.

§ The *Notice of Privacy Practices* could not be read due to the emergent nature of the care or the reason described as: _____

§ I (do) ____ (do not) ____ authorize Advanced Eye Care, or the staff to leave a message with available persons at my home phone number, on my answering machine or with the emergency contact listed above.

§ I (do) ____ (do not) ____ authorize Advanced Eye Care, or the staff to leave a message at my place of employment.

I hereby authorize Advanced Eye Care to provide a diagnosis & optometric treatment to my child or me. I further authorize the release of Protected Health Information to additional physicians or optometrists in order to facilitate continuity of care. I have read & understand the above information & am signing this form voluntarily.

AUTHORIZATION TO RELEASE HEALTH INFORMATION & ASSIGN BENEFITS

I _____, authorize the release of all necessary Protected Health Information & assign all medical & vision benefits to Advanced Eye Care. I also request that payment of authorized Medicare (if applicable) benefits be made on my behalf to Advanced Eye Care for any services furnished to me by Advanced Eye Care. I authorize any holder of medical information related to me to release to the Centers for Medicare & Medicaid Services (CMS) & its agents,any information needed to determine these benefits or the benefits payable to related services.I understand that my signature requests that payment be made & authorizes release of medical information necessary to pay the claim.If item 12 of the CMS 1500 claim form is completed, my signature authorized releasing of the information to the insurer or agency shown.In Medicare assigned cases, the supplier agrees to accept the charge determination of the Medicare carrier as the full charge, & the patient is responsible only for the deductible, copay, & non-covered services. Copay & deductible are based upon the charge determination of the Medicare carrier. I understand that I am ultimately responsible for any bill incurred in this office. Should this account become delinquent, I will be responsible for any & all legal fees, court costs, & collection charges.There will be a service charge for each returned check.This authorization & assignment will remain in effect until revoked by me in writing.A photocopy of this authorization & assignment is to be considered as valid as the original. I request that you file my insurance & I have agreed to & completed all of the conditions listed above. I accept financial responsibility for all charges. I have read & understood this information & I am signing voluntarily.

X_____ _____

Patient or Legal Guardian's Signature Date

Advanced Eyecare's Financial Policy

1. **Proof of Insurance**: Providing quality medical care is our primary goal. We participate with most insurance programs as a service to you. You, the patient, have the ultimate financial responsibility for services rendered. If you do not provide proof of valid insurance at the time of service, you will be responsible for all fees upon checkout.

2. **Coverage and Benefits**: Most medical insurance companies do not cover annual vision exams. Some insurance plans offer routine coverage, if you have questions regarding your coverage benefits, please direct them to your employer or your insurer's representative. It is your responsibility to inform us of any secondary benefits of special requirements, such as Worker's Compensation, or you will be financially responsible for services rendered. Please provide proof of any medical and vision coverage.

3. **Payment is due when services are rendered**: You are responsible for all co-pays and deductibles required by ***your*** insurance contract. Co-pays or co-insurance need to be paid the day services are rendered. Any non-covered services or treatments that you request or your physician recommends are also your responsibility. If you do not have insurance, all fees are due at the time of service. **Initials**: _____

We accept Visa, MasterCard, Discover, CareCredit, Cash and Checks.

4. **Billing, Payments, and Over Payments**: If an overpayment is made by you, a refund will only be issued if there are no other outstanding debts on you or your family's account. Please inform us of changes in address, phone or employer.

5. **Returned Check Policy**: You may be billed a **$35.00** returned check fee or any fees that we incur as a result of your check being returned to our bank.

6. **Retail Goods Policy**: Optical and low vision aid orders will not be placed without a deposit of half of the total.

7. **Refraction**: Medicare and some plans do not cover this service. You will be responsible for a fee of **$45.00** should this apply to you. **Initials**: _____

8. **Cancellation Policy**: When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient. We require that you give our office 24 hours notice in the event that you need to reschedule your appointment. This allows other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $25.00 will be charged to you; this fee cannot be billed to insurance and will be your direct responsibility. Additionally, if a patient is more than 15 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $25.00 cancellation fee will be charged.

_____ _____

Patient or Legal Guardian's Signature Date

Medical / Ocular History

Name:_____ **Date of Birth:**_____
Mailing Address:_____**Phone Number:** _____
Insurance (List both medical *and* vision plans):_____

Are we billing your medical insurance for any medical eye problems or follow up treatment today? ___Yes ___ No

Glasses History:
Do you wear glasses? YES / NO
What difficulties are you having with your current glasses? _____
Are there times you'd rather not be wearing your glasses? YES / NO
Do you have a spare or backup pair of glasses? YES / NO
What do you use for your everyday sun protection? Polarized Sunglasses / UV Blocking Sunglasses / Light - Adaptive (Transitions) Lenses

Contact Lens History:
Do you wear contact lenses? YES / NO
How often do you discard your contact lenses? _____
What type of solution do you use? _____
Rate how your contacts feel immediately after you first put them in:
1 2 3 4 5 6 7 8 9 10
Indicate the time you generally put your lenses in: _____
Rate how your contact lenses feel just before you take them out:
1 2 3 4 5 6 7 8 9 10
Indicate the time you generally take your lenses out: _____
Do you use contact lens rewetting drops? YES / NO If so, how often? _____

If you're a candidate for full time or occasional wear contact lenses would you like to know? YES / NO

Many patients struggle with after-dark sight, is after-dark sight a challenge for you too? YES / NO
How many hours a day do you focus your eyes on a digital screen, like a computer, iPad, or other electronic device? _____
Favorite sport / hobby that you participate in? _____

How would you rate yourself?
__ Easy Going ___ Middle of the Road ___ Perfectionist.

Do you use eye drops for lubrication? ___ Yes ___ No
If yes, how often? _____

Rate your overall dry eye severity on a day to day basis, 1-10:

_____
What would you like to see improve with your dry eye:

_____

Do you feel your Dry Eye is chronic? ___ Yes ___ No
How many dry eye medications / drops are you currently using?
( ) 0 ( ) 1-3 ( ) 4-6 ( ) 7 or more

Are you currently:
Pregnant / Nursing --- On blood thinners --- Have a pace maker

Social History:
Current Smoker Former Smoker Never Smoker

1. Report the type of **symptoms you experience** and when they occur:

Symptoms	At this visit		Within past 72 hours		Within past 3 months	
	YES	NO	YES	NO	YES	NO
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						
Fluctuating Vision						

*SPEED SCORE: _____
*Office Use Only

2. Report the **frequency of your symptoms** using the rating list below:

0 = Never 1 = Sometimes 2 = Often 3 = Constant

Symptoms	0	1	2	3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				
Fluctuating Vision				

3. Report the **severity of your symptoms** using the rating list below:

0 = No problems 1 = Tolerable 2 = Bothersome 3 = Intolerable

Symptoms	0	1	2	3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				
Fluctuating Vision				

Review of Systems (please circle):

Neurological:
Headaches
Migraines
Dizziness/Lightheadedness
Seizures
Numbness/Tingling
Dry Throat / Mouth

Respiratory:
Asthma
Chronic Bronchitis
Emphysema

Endocrine:
Hypothyroid
Hyperthyroid
Diabetes

Ears, Nose, Throat, Mouth:
Allergies / Hay Fever
Sinus Congestion
Runny Nose
Post Nasal Drip
Chronic Cough

Lymphatic/Hematologic:
Anemia
HIV/AIDS

Vascular/Cardiovascular:
Heart/Chest Pain
High Blood Pressure
Vascular Disease

Constitutional:
Fever
Recent Weight Loss/Gain

Cancer:
_____

Allergic/Immunologic:
Eczema
Immuniologic Disease

Bones/Joints/Muscles:
Rheumatoid Arthritis
Muscle Pain / Weakness
Joint Pain / Weakness

Please list any major surgeries:

_____

Please list any daily medications: (or attach a list)

_____

Family History:

Any Family members been diagnosed with the following, please note who in your family had the condition:

Macular Degneration_____ Diabetes_____
Hypertenstion_____ Glaucoma_____

Signature of Patient / Parent / Guardian: _____ Date: _____