Last Name _____ First Name _____ Middle _____

SSN _____ DOB _____ Gender _____

Street _____ Apt _____ City _____ State _____ Zip _____

Race _____ Language _____ Hispanic or Latino: Yes / No

Marital Status: Single / Married / Partner / Divorced / Widowed Student Status: Full Time / Part Time

CONTACT INFORMATION

Home Phone: _____

Day Phone: _____

Cell Phone: _____

Emergency Phone: _____

e-mail: _____

Primary Care MD: _____

Address: _____

Phone: _____ Fax: _____

Referring MD: _____

Address: _____

Phone: _____ Fax: _____

PRIMARY INSURANCE (For Personal Injury Cases, Please Ask for the Worker's Comp/MVA Form)

Payer Name: _____ Effective Date: _____

Insured ID: _____ Insured Name (if not patient): _____

Insured DOB (if not patient): _____

Insured Relationship to patient: Spouse / Parent

Group Number: _____ Group Name: _____

Specialist Co Pay: _____ Referral Required: Yes / No

SECONDARY INSURANCE

Payer Name: _____ Effective Date: _____

Insured ID: _____ Insured Name (if not patient): _____

Insured DOB (if not patient): _____

Insured Relationship to patient: Spouse / Parent

Group Number: _____ Group Name: _____

Specialist Co Pay: _____ Referral Required: Yes / No

PATIENT MEDICAL HISTORY QUESTIONAIRE

Glasses wearer: Yes / No **Contact Lens wearer: Yes / No**

Reason for visit/consultation:_____

_____

ALLERGIES

Allergen	Describe Reaction

OCULAR HISTORY

Disease/Problem	Diagnosed When	Treatment	By Whom

SYSTEMIC MEDICAL HISTORY

Disease/Problem	Diagnosed When	Treatment

If Diabetic: Recent Blood Sugar_____ When_____

FAMILY HISTORY

Family Member	Diagnosis

SOCIAL HISTORY

Do you smoke: yes / no / previously If yes, how long _____

Do you drink Alcohol: yes / no If yes, how much/frequency_____

Do your drink caffeine: yes / no If yes, how much _____

Do you use any recreational drugs: yes / no / formerly

Please complete this form as thoroughly as possible.

OPHTHALMIC MEDICATION

Medication	Strength	Dosage	Eye	To Treat?

SYSTEMIC MEDICATIONS

Medication	Strength	Dosage	To Treat?

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: _____ **Pharmacy Fax:** _____

Signature:_____ **Date:**_____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If your insurance requires a referral, it is your responsibility to obtain one prior to your visit. If you do not have one, you may sign a waiver stating that you will be responsible for payment in full if the referral is not received within one day. Alternatively, you may reschedule your appointment.
- If we have a contract with your insurance company, we will bill your insurance company first, less any copayment(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Fees for service not covered by your insurance policy are due at the time of service. An example of a non-covered service is refractions. Refraction is a procedure necessary for eye doctors to evaluate your vision and/or write glasses prescriptions. Unfortunately, many insurance companies, including Medicare, do not cover this procedure. Our fee for this service is $40 and is expected at the time of check-out. This fee is subject to change.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Name of Patient/Responsible Party (Please Print) Relationship to Patient