

THE OFFICE OF:
ADVANCED EYE CARE CONFIDENTIAL PATIENT INFORMATION

DATE: ____/____/____

PLEASE PRINT

Dr. Mr. Mrs. Ms. Miss _____ Male Female D.O.B.: ____/____/____
Age: ____ SS#: _____-_____-____ Marital Status: Single ____ Married ____ Widowed ____ Divorced ____
Address: _____ City/State: _____ Zip: _____
Hm Ph: _____ Cell Ph: _____ Texting Ok? _____ Email: _____
Employer/School: _____ Occupation: _____
Primary Care Physician: _____ Date of Last Visit: _____
Referred by: Patient: _____ Doctor: _____ Other: _____
Spouse's Name: _____ Employer: _____ Cell Phone: _____
Emergency Contact: _____ Phone: _____

If patient is a child or adolescent, please provide the following information:

Parent/Legal Guardian: _____ Employer: _____
Hm Phone: _____ Cell Phone: _____ Wk Phone: _____

Eye History:

Please **check** if you or your family has any of the following:

	Me	Family		Me	Family
Glaucoma	___	___	Wear Glasses/Contacts	___	___
Cataracts	___	___	Double Vision	___	___
Retinal Disease	___	___	Strabismus (Crossed Eye)	___	___
Headaches	___	___	Amblyopia (Lazy Eye)	___	___
Macular Degeneration	___	___			

Medical History:

Current Weight: ____ **Current Height:** ____

Have you ever had any problems with the following body systems? **If yes, please circle.**

Diabetes	Heart Problems
High Blood Pressure	Lung / Respiratory Disease
Kidney Disease	Arthritis
Thyroid Disease	Cancer
High Cholesterol	

Social History:

Please **circle** to indicate your current Social History

Tobacco Use: Never Smoked
Former Smoker
Current Everyday Smoker
Current Smokeless Tobacco User

Sexually Transmitted Disease: Yes
No
HIV Positive

Alcohol Use: None
1-2 Drinks Daily
Alcohol Dependence
Social Use Only

Blood Transfusion: Yes
No
HIV Positive

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. Downloaded or printed description of your medical and/or vision benefits.
3. Authorization to file insurance claims and receive direct payment for services rendered.

Primary Medical Insurance: _____ **Policyholder:** _____
Policyholder's D.O.B.: _____ **Relationship to Patient:** _____

Secondary Medical Insurance: _____ **Policyholder:** _____
Policyholder's D.O.B.: _____ **Relationship to Patient:** _____

Vision Plan: _____ **Policyholder:** _____
Policyholder's D.O.B.: _____ **Relationship to Patient:** _____

**ADVANCED EYE CARE
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.

Patient or Legal Guardian's Signature Date

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.

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, including Medicare, some Medicaid plans and Tricare 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. **Refraction Policy:** A refraction is performed to determine whether a glasses prescription is needed or an existing prescription needs to be changed. It is also frequently **needed** information for the doctor to monitor the progression of a disease process like cataracts or macular degeneration. There is a separate fee for this test. It is not included in the exam. Most insurance, including Medicare and Medicare Advantage plans, **DO NOT COVER THIS FEE**. It will be due at the time of service.

4. **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.

5. **Our Responsibility to Report Non Compliance:** Many insurance contracts request that we report patients who repeatedly refuse to pay co-pays, deductibles, and non covered services or repeatedly "no show" for appointments. Such habits could result in you losing your insurance coverage.

6. **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.

7. **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.

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

9. **Missed Appointment Fee:** Kindly give us 24 hours notice prior to your appointment time. Appointments cancelled less than 24 hours or missed appointments will result in a \$25 fee billed to your account.

Patient Signature

Date