EYECARE EAST PLLC

PATIENT INFORMATION AND HISTORY QUESTIONAIRE

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ ST: _____ Zip: _____

Telephone Preferred: _____ Alternative: _____

Email: _____ SSN: _____

Date of Birth: _____/_____/_____ Occupation/Grade: _____ Employer/School: _____

Sex: _____ Race: _____ Ethnicity: _____

How did you hear about us _____

MEDICAL INSURANCE

Primary Medical Insurance: _____ ID #:_____

Primary Policyholder's Name: _____ Relation to Patient: _____

Policyholder's Date of Birth: _____/_____/_____ Policy holder's SSN: _____

Secondary Medical Insurance: _____ ID # _____

Secondary Policyholder's Name: _____ Relation to Patient: _____

Policyholder's Date of Birth: _____/_____/_____ Policyholder's SSN_____

VISION PLAN

Vision Plan: _____ Policyholder's Name: _____

Primary Policyholder's Name: _____ Policy holder's SSN: _____

Date of Last Eye Exam: _____ Last Eye Doctor: _____

What Concerns are you having with your Eyes/Vision? _____

_____

Do you use any of the following: Alcohol Yes No If Yes, how much _____
Tobacco Yes No If Yes, how much _____
Illegal Drugs Yes No If Yes, how much _____

Have you ever been infected with: (circle) Gonorrhea Hepatitis HIV Syphilis

You are required to Answer These Questions by Your Insurance Provider

Primary Care Physicians: _____ Date of Last Visit: _____

Do You Have Any Allergies? (If yes, please list)_____

Are You Allergic To Any Medications? _____

What Medications Are You Currently Taking? (Prescribed, Over-the-Counter, and Eye)

_____

REVIEW OF SYSTEMS: Do you currently, or have you ever had problems in the following areas:

Eye	**NO**	**YES**
Loss of Vision	____	____
Blurred Vision	____	____
Double Vison	____	____
Eye Injury	____	____
Flashes	____	____
Floaters	____	____
Glare/Halos	____	____
Crossed/Lazy Eye	____	____
Cataracts	____	____
Glaucoma	____	____
Eye Pain/Soreness	____	____
Endocrine		
Thyroid	____	____
Bones/Joints/ Muscle		
Rheumatoid Arthritis	____	____
Joint Pain	____	____
Hematologic		
Anemia	____	____

Vascular/Heart	**NO**	**YES**
Diabetes (Type___)	____	____
High Blood Pressure	____	____
Heart Pain	____	____
Neurological		
Headaches	____	____
Migraines	____	____
Seizures	____	____
Respiratory		
Asthma	____	____
Chronic Bronchitis	____	____
Emphysema	____	____
Skin Disorders	____	____
Psychiatric	____	____
Ear/Nose/Throat	____	____
Allergies/Hay Fever	____	____
Genitourinary		
Kidney/Bladder/Other	____	____

Other: _____

FAMILY MEDICAL HISTORY: Does anyone in your family have any of these conditions?

Ocular Conditions	**NO**	**YES, Family Member**
Blindness	____	_____
Crossed Eye	____	_____
Glaucoma	____	_____
Macular Degeneration	____	_____
Retinal Detachment	____	_____

Systemic Condition	**NO**	**YES, Family Member**
Diabetes (Type___)	____	_____
High Blood Pressure	____	_____
Cancer	____	_____
Heart Disease	____	_____

Persons Authorized for Release of Information: _____

_____

_____

AUTHORIZATION

By signing, I attest that I am either the patient being seen or the parent/legal guardian of this minor being seen. I certify that I have read and understood the above information to the best of my knowledge and that I have provided the information as accurately as possible. I understand that providing incorrect information can be dangerous to my health. I give permission for the doctor(s) to examine, diagnose, and initiate treatment as deemed appropriate. I authorize the doctor to release any information including the diagnosis and a summary of any treatment or examination rendered to me or my child to appropriate third party payers or other health care providers. I authorize and request my insurance company to pay all appropriate benefits directly to the doctor. I acknowledge that I have been given the opportunity to read a copy of the privacy practices of Eyecare East, PLLC.

_____ _____

Signature of Patient (or parent/guardian if a minor) Date

Office Use Only: Refused to Sign _____ Communication Barrier _____ Emergency _____

EYECARE EAST PLLC

OUR FINANCIAL POLICY

We appreciate your trust in us and we appreciate the opportunity to serve you. We are committed to providing the highest level of eye care to our patients. To ensure that our patients fully understand our billing process, we ask that you read and sign this financial policy statement.

PATIENT PAYMENTS

Payment is due at the time of service. You may use cash, check, credit card, or debit card to pay your account. Without exception, it is the responsibility of the patient to pay his/her co-payment and any unpaid portion of the deductible at the time of service. Any additional co-payments, deductibles and/or co-insurance will be billed to the patient as indicated by your insurance carrier on their Explanation of Benefits (EOB). All patients without insurance must pay in full at the time services are rendered.

INSURANCE COVERAGE

We make a good faith attempt to verify your insurance coverage. We are not able to guarantee that the information given to us by your insurance is correct. It is your responsibility alone to know what insurance plan you are on, supply us with the correct information at the time of your visit and know what services may or may not be covered by your insurance. We encourage you to refer to your benefits manual if you have any questions about covered services. Be aware that some and perhaps all of the services provided may be not be covered by your insurance. You will be responsible for payment of all non-covered services at the time they are rendered.

INSURANCE PAYMENTS

Regarding insurance, your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We require certain co-payments, deductibles or prepayment amounts depending on the type of insurance and insurance carrier. Be assured our office works diligently to obtain payment from your insurance company. However, if we file your insurance, and the claim has not been paid for any reason within 60 days, we require that you pay the balance using one of the approved payment methods without exception. In the event that your insurance pays us after that time, you will be reimbursed.

ESTABLISHED PATIENTS / MISSED / LATE CANCELLED APPOINTMENTS

Please give us at least 24 working hour's notification if you cannot keep an appointment. This courtesy will allow others to be seen. We do realize that emergencies arise.

RETURNED CHECKS

Our bank charges us whenever a patient presents a check that does not have funds available. Therefore, we must charge you a $35.00 handling fee. All future visits will need to be paid with either cash or a credit card. We welcome the opportunity to discuss any aspect of our financial policy. Please ask to our office manager if you have any questions, comments, or concerns. We sincerely regret having to maintain such a policy and hope you understand our reasoning.

-Patient Authorization-

I have read, understand, and agree to abide by the terms stipulated above. I request that payment of benefits be made to Eyecare East PLLC. I hereby authorize the release of any information necessary to determine liability for payment and obtain reimbursement on any claim. I further authorize the use of my signature below on all insurance submissions for services rendered or to be rendered. I agree that a photocopy of this agreement shall be as valid as the original.

Patient Name _____ Date of Birth _____

Patient Signature _____ Date_____

EYECARE EAST PLLC

CONTACT LENS EXAM AND FITTING POLICES

Eyecare East, PLLC provides exceptional professional contact lens services. If you are interested in contact lenses or currently wear contact lenses, our Doctors or staff can discuss you options with you for contact lenses. Our recommendations are individually tailored to each patient and are based on many factors including, available modalities, your visual needs, and your overall eye health. ***Contact lens exams and fitting charges are not typically covered by vision plans and therefore result in additional charges in addition to your routine examination copayment.*** The contact lens exam and fitting charges are dependent on the complexity of the type of contact lens that you currently wear or are being fitted, and the complexity of the insertion and removal instruction if needed.

CONTACT LENS EXAM

A contact lens exam is a separate part of a comprehensive eye examination and requires additional testing that non-contact lens wears do not need. Patients wearing contact lenses requires more of the doctor's time and expertise. In order to prescribe contact lenses, the doctor must complete several additional tests including:

1. Evaluation of the health of the eye, with special observation of the cornea, eyelid, and conjunctiva. This evaluation will determine if the contact lens is affecting the eye health or has the potential to affect the eye health in the future.
2. Determination of the proper contact lens prescription is based on the individual's patient's glasses prescription, visual needs, quality of the tear film, and corneal health and curvature.
3. Examination of the contact lens on the eye to ensure proper alignment on the cornea.
4. Measurement of the vision with the contact lenses and determination if adjustments needed to be made in the contact lens prescription.

CONTACT LENS EXAMAINATIONS AND FITTINGS HAVE DIFFERENT LEVELS OF DIFFICULTY. THIS DEPENDS ON THE TYPE OF CONTACT LENSES NEEDED AND THE VISUAL REQUIREMENTS OF THE PATIENT'S EYES, THEREFORE THE DIFFERENT LEVELS OF CONTACT LENS EXAMS AND FITTINGS RESULT IN DIFFERENT LEVELS OF FEES FOR THOSE SERVICES.

YOUR VISION PLAN AND CL MANAGEMENT/FITTING FEES

Most, if not all, vision plans require doctors to separate routine comprehensive eye examination fees from the services provided for contact lenses. More time and testing is required for the patient who wears contact lenses in addition to the management of ocular health risks associated with wearing contact lenses. Most, if not all, vision plans treat contact lens services as an additional and separate exam from the routine eye examination.

WHAT IS A CONTACT LENS PRESCRIPTION?

Contact lenses are a medical devices that can only be dispensed by a prescription. Contact lens prescriptions expire after one year (or sooner if the doctor determines that there is a medical reason for a shorter expiration). They must be regarded with the same caution as you would for a prescription drugs, which includes expiration dates and follow-up visits with the eye doctor. Your eyes go through gradual changes in size, shape, and physiological requirements (such as oxygen) while you wear contact lenses and these changes can affect the health of the cornea and need to be monitored at least every year. The federal government requires contact lens prescriptions to expire after one year for these reasons.

-Patient Authorization-

I have read, understand, and agree to abide by the terms stipulated above. (Please ask the receptionist if you have any questions about CL fees prior to your exam.) I understand that CL management, fitting and exam fees are not covered by insurance and agree to pay Eyecare East, PLLC on the day that services are rendered. I understand that, without the exam, management, and fitting procedures, I will not receive diagnostic CLs and or CL prescription.

Patient Name _____ Date _____

Signature _____ Patient/ Authorized Guardian