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Patient Information

Last Name_____First Name_____MI_____Age___

Home Address_____

Home Phone_____ Cell Phone_____ Business Phone_____

E-Mail Address_____

Date of Birth_____ Gender: M__F__ Martial Status: M__W__S___D__

Social Security #_____ Drivers License#_____

Occupation_____ Employer_____

Spouse / Parent Name _____Phone#_____

Nearest relative name or friend name not living with you_____

Their contact phone# and Address_____

Insurance Carrier#1_____

Insurance Carrier#2_____

Family Doctor_____Referred By_____

I hereby authorize Premier Eye Clinic to furnish/fax information to insurance carriers/Medicare concerning my illness and treatment and I hereby assign to Premier Eye Clinic all payments for medical service rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance.

Patient Signature_____Date_____

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements are made in advance. Should it be necessary to obtain legal or collection services on unpaid balances, you will be responsible for all legal or collection service fees.

Patient Medical Information Sheet

Date_____

Last Name_____First Name_____MI_____Age___

What problem are you having with your eyes?_____

_____

Do you wear glasses or contact lens: Yes_____ Glasses_____Contact Lens_____ No_____

If glasses, what type: reading_____ distance_____ Bifocal_____

If contact lens, what type: soft____ hard____ bifocal_____ Astigmatism-correcting_____

When did you last change your glasses or contact lens_____

Have you had any eye laser or surgery, or have any eye injury before: Yes_____ No____ If yes, please explain:

Are you presently taking eye drops: Yes___No___ If yes, please list_____

Are you allergic to any eye drops: Yes___No___ If yes, please list_____

Are you allergic to following medications: Penicillin___ Sulfa___ Steroids___Aspirin___ Latex___Others_____

What other medications are you taking_____

Do you smoke: Yes___ No___ If yes, pack per day_____ Do you drink alcohol: Yes___ No___

Have you or your family ever had the following? (Please check)

	You	Your Family		You	Your Family
Diabetes	___	_____	Cancer	___	_____
High Blood Pressure	___	_____	Blindness	___	_____
Heart Disease	___	_____	Glaucoma	___	_____
Lung Disease	___	_____	Cataracts	___	_____
Macular Degeneration	___	_____	Lazy Eye	___	_____

Other medical conditions you have that are not listed above_____

Besides your eyes, have you had any change in your general health recently? If so, please list.

Patient Consent Form

The department of Health and Human Service has established a “Privacy Rule” to help ensure that personal health care information is protected for privacy. The Privacy Rules were also created in order to provide a standard for health care providers to obtain their patients’ consent for use and disclosure of health information about the patient to carry out treatment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), may have to disclose personal health information for purpose of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You have the right to review our privacy notices for more complete uses and disclosures before signing this form. You may refuse to consent to the use or disclosure of your personal health care information, but this must be in writing. You also have the right to request restrictions of how your PHI is used. However, under this law, we have the right to refuse to treat you should you choose to refuse to disclosure your personal health information (PHI). If you choose to give consent in this document, at some future time you may request to refuse the use of all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any questions on this form, please speak with our Administrator.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name_____ D.O.B_____

Signature_____ Date_____

If signed by patient representative, state relationship to the patient_____

CONSENT FOR DILATING EYE DROPS

In order to thoroughly examine your eyes and diagnose certain eye diseases such as Glaucoma and Macular Degeneration, it is usually necessary to administer dilating drops. Dilating drops enlarge the pupil of the eye to allow for the examination of the inside of the eye: without pupil dilation, the doctor gets only a limited view of the eye. These drops usually cause blurred vision and makes driving, reading and focusing on near objects difficult or impossible until pupils return to normal size. The length of time that the vision will be blurred and the degree of vision impairment varies from person to person.

PATIENT STATEMENT

I, (print name)_____, hereby authorize Premier Eye Clinic's doctors, technicians or other assistants to administer dilating eye drops. I understand that these eye drops are necessary to diagnose my eye conditions. I further acknowledge that I have been warned of the potential risk to drive and will take appropriate steps to reduce this risk by not driving immediately after my eyes have been dilated or by wearing sunglasses while driving or have a designated driver.

Patient Signature or Authorized Representative _____Date_____

Refraction / Contact Lens Fitting Service and Fee

A Refraction is the process of determining if there is a need for corrective eye glasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contacts.

Most medical insurance plans, including Medicare, do not cover routine refractions or contact lens fitting. Medicare allows that we charge separately for that portion of the examination, since it is not a covered service.

If you have a separate vision plan that covers routine or annual eye examinations and / or glasses, or contact lens please let us know. Your vision plan may assist you with your eye care needs that are not covered by your medical plan.

Our office refraction fee is $30. Our contact lens fitting fee ranges from $100 to $200 depending on lens type and fitting scope.

The fee above is collected at the time of service in addition to any co-payment your health insurance plan may require. Should your health insurance plan reimburse us for the refraction, or contact lens fitting, we will reimburse you accordingly.

If you have any questions regarding Medicare and insurance policies and procedures, please do not hesitate to ask. We will do our best to assist you.

Patient Acknowledgement

I have read the above information and understand that the refraction / contact lens fitting is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at the time of service. I understand that any co-payment, co-insurance, or deductible I may have are separate from and not included in the refraction / contact lens fitting fee.

Patient Name (print)_____ D.O.B_____

Patient Signature_____ Date_____