Patient Information Date _________________

Patient's Name ____ Ethnicity: _________________

Sex: Male Female Marital Status: ___________ Date of Birth: ______________ Age:______ Race: ________

Social Security #: __________________ Driver's License #: ___________________________

If minor, Patient's Name & Social Security #: _______________________________

Mailing Address: ____

City: _______________________ State: _____ Zip: _____________ Email Address: ________________________

Home Phone: ________________ Cell Phone: _______________

Person to contact in case of emergency: _________________________ Phone Number: ______________________

Who is your referring Doctor: _________________________________ Phone Number: ______________________

Who is your Primary Care Physician (PCP)? _________________________ Phone Number: __________________

PCP Address: _______________________________________ City:______________ State: _____ Zip: _________

Who is your Employer (Occupation)? :____

Primary Insurance: _____________________________ Secondary Insurance: _____________________________

Policy Number: ________________________________ Policy Number: __________________________________

Policy Holder's Name: __________________________ Policy Holder's Name: ____________________________

Policy Holder's Date of Birth: ____________________ Policy Holder's Date of Birth: _______________________

Authorization for Use or Disclosure of Protected Health Information

I authorize my physician and/or administrative and clinical staff at Quality Eye Care to disclose general medical information and other protected health information to the following persons and/or entitles listed below. If no one is listed below, protected health care information will not disclosed. This authorization to use and disclose this protected health information is being submitted by my request and shall be in force and effect until revoked in writing by me, or if the purpose of the disclosure is related to research.

Name of Person or Entity Relationship

____ ___________________________

____ ___________________________

History of Present Illness

Are you experiencing any of the following?

Blurry Vision	yes / no
Dry Eyes	yes / no
Injury to the affected eye	yes / no
Pain or Irritation	yes / no
Double vision	yes / no
Watery eyes	yes / no
Discharge	yes / no
Cataract	yes / no
Flashes of light	yes / no
Floaters	yes / no

If others, explain:

____

____

Social History

Do you drink? Yes / No / Occasional / Rare

Use of drugs? Yes / No

Do you smoke? Yes / No / Former

If yes or former, please note how often you smoke or when you quit.

____

____

Have you ever had any eye surgeries or other eye procedures? List types, dates, and surgeons name:

____

____

____

Do you have any known eye disease? ____________________________________

____

Does anyone in your family have any eye disease or medical disease? And who was diagnosed?

____

Medical History

Are you allergic to any medications? ____________________________________

Please list all major illnesses, hospitalizations, and surgeries with their approximate dates:

1. ____________________ 2. ____________________
3. ____________________ 4. ____________________
5. ____________________ 6. ____________________

Please circle the following that applies:

·Diabetes	·High blood pressure	·Heart Disease	·Heart Attack
·Chest Pain	·Irregular Heart Beat	·Pacemaker	·High ·Cholesterol
·Blood Clots	·Epilepsy/ Seizures	·Fainting	·Stroke
·Cancer	·HIV/AIDS	·Hepatitis	·Asthma
·Depression	·Arthritis Lyme Disease	·Sickle Cell Anemia	·Ulcerative Colitis
·Skin Conditions	·Lupus Thyroid Disease	·Parkinson	·Multiple Sclerosis
·Kidney Disease	·Headaches	·Bronchitis Emphysema	·Pregnant/ Nursing
·Arthritis	·Thyroid Disease	·Vertigo	

Patient Medication Form

Patient Name:

Pharmacy:

Name of Medication: Prescription/ Non- Prescription	Strength/ Dose	How do you take it?

Guarantor

Name: ______________________________________ Relationship to Patient: ______________________

Address:____ Home Phone Number: _________________

Social Security Number:____________________ Driver's License Number: _________________________

The patient or responsible party agrees to the Physician's reasonable and customary fee for medical services. Any guarantor over the age of 18 will be held responsible for all charges incurred.

Responsibility to Provide Proof of Insurance and Obtain Referral

Please be aware of any requirements of your insurance policy relating to referrals or authorizations for services are provided in advance of any treatment or services. If you do not obtain the necessary referral for care you will be responsible at check-out for the full cost of service provided. Any changes in insurance must be notified to Quality Eye Care, Inc immediately.

Refraction Policy

Medicare and most insurance plan does not cover routine examinations and refractions (a refraction is the examination used to determine your prescription for glasses or contacts) so if your visit is determined to be routine and not medical in nature, you will be responsible for the entire charge. If you elect to have a refraction done during a medical visit, you will be required to pay a fee of $35.00**. This fee is collected at the time of service in addition to any copayment your plan may require.** Should your plan pay us for the refraction, we will reimburse you accordingly.

Dilation Policy

It may be necessary to dilate your eyes during the course of your eye examination or treatment. Dilation results in sensitivity to light and inability to see well at close range or distance for a few hours. We provide free disposable sunglasses or dark sunglass inserts. Patients should wear sunglasses, be cautious walking and going up and downstairs. We recommend avoiding driving and operating dangerous machinery immediately afterwards. We recommend that someone accompany you to drive you home or that you wait until your eyes return to normal so you can drive safely home.

Missed Appointment Policy

We want to thank you for choosing us as your health care provider. In order to give you and all our patients, the best possible care, we request that you review our policy regarding missed appointments. A missed appointment is when you fail to show up for an allotted appointment time, without a phone call or cancellation notice of at least 24-hours. Please remember that we have reserved appointment times especially for you. Therefore, we request at least a 24 hour notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients. If you are unable to keep your scheduled appointment time, please call our office at least 24-hours in advance in order to avoid a missed appointment fee. This charge is not covered by insurance. Your phone call is critical in helping us provide continuous care to all of our valued patients. If you fail to give us notice of your missed appointment the first time, a notification will be sent to you regarding missed appointments. If you missed your appointment the second time and so forth, you will be charged a $35 missed appointment fee.

Return Checks

Payment to Quality Eye Care is expected to be paid in a responsible and timely manner. However, on occasion, we have received checks from vendors that have been returned by the bank for insufficient funds or bounced due to the account being closed. If a check is returned, there will be a $35 fee in addition to the original amount owed. No post-dated checks will be accepted. If the bank is at fault, a letter must be submitted on the original bank letterhead paper and must state that the bank made an error that caused the check to be returned. Upon receipt of bank letter, we will redeposit the original check and any related charges will be waived.

Medicare

Medicare provides services to patients for medical conditions only. Those services are not limited if they are medically necessary. Medical conditions may include cataract, glaucoma, diabetes, dry eyes, retinal issues, and visits after cataract surgery or other diseases and conditions. All test as well as the examination will be billed to Medicare.

If you do not have a supplement to your Medicare you will be required to pay all charges up to the deductible amount and the 20% co-insurance at check-out. If you have met your Part B Deductible, please bring a copy of your Medicare Explanation of Benefits with you to your visit. We will collect the co-insurance amount in these cases. If your Medicare Supplement has a copayment or does not pick up the Part B deductible, you will be asked to pay these charges at check-out as well.

Assignment of Benefits

I herby authorize and assign all payments and/or insurance benefits for medical services and/or surgical procedures rendered to patient, directly to Quality Eye Care, Inc. I hereby authorize Quality Eye Care, Inc to release medical information necessary to obtain payment. I understand I am financially responsible for all charges not covered by my insurance plan. .

Assignment of Medicare Benefits

I herby authorize and assign all payments of authorized Medicare benefits for medical services and/or surgical procedures rendered to patient, directly to Quality Eye Care, Inc. I hereby authorize Quality Eye Care, Inc to release medical information necessary to obtain payment. I understand I am financially responsible for all charges not covered by Medicare for which I have signed an ABN.

Patient Signature: ____ Date: ______________

Witness Signature: ____ Date: ______________