Registration : **1960 Eye Surgeons, P.A.**

Date	Account ID (office use only)	Chart ID (office use only)	Other ID (office use only)

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age

Address: Home number:
Cell number:
Work number:
Email:
Pharmacy Name: Pharmacy Number:
Emergency Contact:

Provider	Family Physician	Referring Physician

HIPAA Approved Contacts

Last Name	First Name	Middle	Gender	Birthdate	Relationship to patient

Home Number:	Cell number:	Work Number:

Last Name	First Name	Middle	Gender	Birthdate	Relationship to patient

Home Number:	Cell number:	Work Number:

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to 1960 Eye Surgeons, P.A. , all medical benefits, if any, otherwise payable to me for secures rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating obtaining payment for services rendered to me, and conducting healthcare operations.

Signature:	Date:

PATIENT INFORMATION: PLEASE PRINT Sex M F Marital Status: M S D W

Name _____ Birth Date _____ Age ____

Address _____City _____ State _____ Zip _____

Home Tel. # _____Work Tel.# _____ Cell/Alt # _____

*Check preferred telephone number to call Email: _____

Referred By: _____ Family Physician: _____

MEDICAL STATUS AND HISTORY

Complaint - Please state reason for today's visit: _____

_____

Symptoms - Please circle: Blurred Vision/Recent Change in Vision Double Vision Glare Difficulty Reading
Eye Pain Light Sensitivity Halos Tearing Mattering Redness Eyelid Crusting
Eyelid Swelling Eye Injury Flashes of Light Floaters or Spots Shadows in Vision

Are you using any eye medications? No Yes. If Yes, list: _____

Do you have any allergies to medication? No Yes. If Yes, list: _____

Previous eye history: Cataract / Glaucoma / Injury _____

Do you wear glasses / contacts? No Yes. _____ Contacts: Disposable / Daily / Gas Perm / Overnight Wear

Prior hospitalizations for: _____

General surgery for: _____

Medications being used: _____

_____

REVIEW OF SYSTEMS Do you have: Diabetes High Blood Pressure Asthma Arthritis Cancer Epilepsy
Migraine Heart Condition Thyroid Disease

Do you currently have any of the following problems:	Yes	No	If Yes, please explain:
Chronic fever, unexpected weight loss/gain fatigue	☐	☐	_____
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat)	☐	☐	_____
Heart problems (e.g., chest pain, irregular heart beat)	☐	☐	_____
Respiratory problems (e.g., shortness of breath, wheezing, coughing)	☐	☐	_____
Gastrointestinal problems(e.g., heartburn, abdominal pain, diarrhea,vomiting)	☐	☐	_____
Urinary problems (e.g., pain or discomfort, blood in urine)	☐	☐	_____
Skin problems (e.g., rashes, excessive dryness)	☐	☐	_____
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)	☐	☐	_____
Neurologic problems (e.g., numbness, weakness, headaches, paralysis)	☐	☐	_____
Psychiatric problems (e.g., depression, anxiety)	☐	☐	_____

FAMILY/SOCIAL HISTORY Is there any family history of the following conditions? If Yes, circle:
Glaucoma Blindness Color Blindness Macular Degeneration Cataracts Crossed-Eyes Other Eye Disease
Diabetes High Blood Pressure Heart Disease Cancer Migraine Other _____

Do you smoke? No Yes. How much? _____ Drink alcohol? No Yes. How much? _____

Your Occupation:_____ Employed By: _____

Employer's Address _____City _____State ____Zip _____

Person responsible for bill _____

INSURANCE INFORMATION ☐ PPO ☐ HMO ☐ Workman's Comp ☐ Other_____

(Only if we are a participant in your insurance plan will this office file.)

Do you have an insurance change since last visit? ☐ yes ☐ no

Insurance Company Name _____

I hereby authorize payment directly to the office for professional services rendered and I shall be personally responsible for any unpaid balance to the doctor. I hereby authorize the attending doctor to release any information concerning my examination or treatment.

Insured Patient or Parent (if patient is a minor) Date

Information update: New Patient

Date:_____

Patient Name: _____ Birth Date: _____

REFRACTION FEE

One of the most important parts of your eye exam today is the refraction. That is the part of the eye exam by which we determine your best visual acuity and whether you can be helped by new glasses. It is **NOT** a covered service by Medicare and some plans. Our office fee for refraction is **$55.00**, and unless your plan covers the refraction charge, this fee is collected at the time of service **in addition to any co-payment your plan may require.** If you choose not to do the refraction, we will not be able to do a comprehensive exam.

I have read and understand the above refraction policy. X_____

Signature of Patient or Representative Date

CONTACT LENS FITTING FEES

Contact lens fitting is charged separately from your eye exam. The fitting fee includes determination of the lens type, curvature and power. Also included are trial contacts as required and visits related to the contact lens fitting for 3 months. The fitting fee varies greatly depending on the type of contact lens and the complexity of the fit. A fitting fee is charged even if there is no change to your contact lens prescription.

The contact lenses are charged separately and our prices are competitive with national suppliers. Contact lenses are not covered by your health insurance.

I have read and understand the above contact lens policy. X_____

Signature of Patient or Representative Date

CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. **Office appointments rescheduled or cancelled with less than 24 hours notification are subject to a $40.00 fee.** Patients who do not show up for their appointment will be considered as **NO SHOW** and subject to a **$40.00** fee. These fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

I have read and understand the above Cancellation/No Show PolicyX_____

Signature of Patient or Representative Date

FINANCIAL POLICY

As physicians, we are committed to giving you the best possible medical care. To achieve this goal, we need your assistance and understanding of our payment policy. We must emphasize that as your physicians, our primary relationship and concern is with you and your health, not with your insurance company.

Managed Care Plans: As providers we ask that the co-pay and deductibles (if applicable) be paid in full at the time of your visit. We accept assignment for services covered and bill the insurance. Any balance outstanding, following payment from insurance, will be billed to you.

Medicare: We are participating Medicare providers and will file your medical claims to Medicare for you. Services routinely not covered by Medicare (i.e. Refraction/Routine Exams) will require payment at the time of service. We also request payment for the 20% co-insurance of the allowable Medicare charges and any deductible (if applicable) that has not been met at the time of your visit.

Financial Agreement: We will be glad to discuss your proposed treatment and the cost of those services if you have questions about your insurance coverage of a medical service. HOWEVER, please be aware that your insurance is a contract between you, your employer (if applicable) and the insurance company. We are not a party to your contract. Unfortunately, not all services are covered benefits in all contracts.

All charges for services are your responsibility at the time of service. Collection action may be taken for any balance on accounts that are past due. We realize that emergencies do arise and may affect timely payment on your account. If such extreme cases do occur, please contact our office promptly for assistance in management of your account.

If you have any questions regarding the above, any uncertainty regarding insurance coverage or request for payment please do not hesitate to ask. We are here to assist you.

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding health information. I understand that this information can and will be used to :

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practice containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practice from time to time to obtain a current copy of the Notice of Private Practice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.
I understand and agree to the financial and HIPAA policies for 1960 Eye Surgeons, PA.

_____ _____

Patient/Legal Guardian Signature Date

_____ _____

Witness Date