PLEASE BRING INSURANCE CARD(S) & PHOTO ID WITH YOU TO EACH APPOINTMENT

PATIENT INFORMATION

Patient Name: First Middle Last		Date of Birth:	Social Security Number:
Mailing Address:	City:	State:	Zip:
Phone:	Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed		
Email Address:	Would you like to receive emails from us? ☐YES ☐NO		
Race:	Ethnicity:		
Language: ☐English ☐Spanish ☐Other:_____	Sex: ☐M ☐F	Gender Identity: ☐M ☐F ☐Other:_____	
Emergency Contact:	Phone	Relationship	
Do you wish to provide your emergency contact with access to your health information? ☐YES ☐NO			
Employer Name:	Occupation:	Employer Phone:	
Employer Address:	City:	State:	Zip:
Is your visit due to a job related accident? ☐ YES / ☐ NO If yes, indicate the date of injury:			

GUARANTOR INFORMATION: (only if different from above)

Guarantor Name: First Middle Last		Date of Birth:	Social Security Number:
Mailing Address:	City	State:	Zip:
Relationship to Patient: ☐ Spouse ☐Parent ☐ Legal Guardian ☐ Legal Representative			
Employer Name:	Occupation:	Employer Phone:	
Employer Address:	City:	State:	Zip:

PRIMARY INSURANCE: IS A REFERRAL REQUIRED? ☐YES / ☐ NO

Insurance Name:			Insurance Phone:
Insurance Address:	City:	State:	Zip:
Policy Holder's Name: First Middle Last		Date of Birth:	Social Security Number:
Policy ID Number:	Policy Group Number:		Policy Effective Date:

SECONDARY INSURANCE: IS A REFERRAL REQUIRED? ☐YES / ☐ NO

Insurance Name:			Insurance Phone:
Insurance Address:	City:	State:	Zip:
Policy Holder's Name: First Middle Last		Date of Birth:	Social Security Number:
Policy ID Number:	Policy Group Number:		Policy Effective Date:

PREFERRED PHARMACY:

Pharmacy:	City	State	Zip

OUR OFFICE POLICY REGARDING PATIENT FINANCIAL RESPONSIBILITY

Payment for services is due in full at the time services are rendered, unless we participate with your insurance. As a courtesy, we will bill participating provider insurance on the patient's behalf. Your co−pay, any deductible, or any amount not covered by your insurance is due at the time of your visit. All cosmetic procedure fees must be paid in full before the procedure is performed. The fees that we charge are within the usual range for our area and specialty. **If we are not a participating provider with your insurance, or if you do not have insurance, you will be expected to pay the entire fee, in full, at the time of your visit.** If we do not participate with your insurance, we can provide you with information for you to submit to your insurance carrier for potential reimbursement.

If you have an insurance plan that requires a referral, you will need to contact your primary care physician and have them forward a referral to our office. We may not be able to see you if a referral is not on file with our office by the scheduled appointment date.

An eye examination may or may not be covered by insurance. Routine (vision-only) eye exams are not a covered service of Medicare and many other insurance companies. If there is no medical problem, such as glaucoma or cataracts, then the exam is considered "routine" and is not a covered benefit. Please consult with your insurance carrier.

A refraction is a procedure in which we determine the best possible visual acuity and function of your eye. This is essential medical information and used for medical treatment and in order to generate a glasses prescription if needed. These plans consider the refraction a "vision" service not a "medical" service. **A refraction is NOT a covered service by Medicare and many other insurance plans. This fee (currently $45 but subject to change) is collected at the time of service in addition to any copayment, deductibles, or other coinsurances your plan(s) may require.** Should your plan pay us for the refraction, we will reimburse you accordingly.

We will gladly discuss any questions you have regarding our billing and your insurance coverage. Please call to speak with a receptionist if you have any questions regarding our policies.

X_____ _____

Signature of Patient or Legal Guardian **Date**

Patient Name: _____ DOB: _____/_____/_____

RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

PARTICIPATING INSURANCE:

Regional Eye Associates is a participating provider with a variety of insurances, and we bill directly as a courtesy to you. We accept payment for covered services from these insurance plans in accordance with our contracts. You are responsible for applicable co−insurance and deductible amounts, as well as payment for services that are not covered by insurance, such as routine eye exams, refractions and cosmetic procedures. If your health care insurance requires a referral from your primary care physician, you are required to obtain this referral prior to arriving for a specialty physician office visit.

NON-PARTICIPATING INSURANCE:

If we are not a provider for your insurance carrier, and you wish to see one of the doctors, you are responsible for payment of all charges at the time of service. You are then responsible for submitting the claim to your insurance company for possible reimbursement.

MEDICARE:

We are participating providers of the Medicare Program. We will accept assignment on all claims and bill Medicare directly for you. Patients are responsible for meeting their annual deductible and paying for the 20% coinsurance. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be billed. This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim.

Note: If you have recently joined (or changed) to a Medicare HMO or Medicare Advantage Plan, please let our staff know so we can update your records and advise you if we are participating providers.

RELEASE OF INFORMATION:

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician.

X_____ _____

Signature of Patient or Legal Guardian **Date**

MEDIGAP POLICY HOLDERS ONLY:

If you have a supplemental policy, and it is a **MEDIGAP** policy to which your Medicare carrier automatically "crosses over," we are required to keep a separate signature on file. *I request authorized MEDIGAP benefits to be made on my behalf for any services furnished to me. I authorize any holder of medical information to release any information needed to determine these benefits or the benefits payable for related services.*

X_____ _____

Signature of Patient or Legal Guardian **Date**

Patient Name: _____ DOB: _____/_____/_____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I consent to Regional Eye Associates, Inc. (the "**Practice**") using and disclosing my protected health information (**PHI**) to carry out treatment, payment and healthcare operations (**TPO**). I acknowledge that I have had the right to review the Practice's Privacy Policy prior to signing this consent, which provided me a more complete description of potential uses and disclosures of my PHI. I am aware that the Practice reserves the right to revise its Privacy Policy at any time. I am also aware that a revised Privacy Policy may be obtained by my forwarding a written request to the Practice.

I consent to the Practice calling my home, cell phone or other designated location and leaving a message on my voicemail or in-person in reference to any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and other matters incident to my treatment. I hereby consent to the Practice mailing any items that assist the Practice in carrying out TPO to my home or other designated location, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. I consent to the Practice e-mailing me any items or communications that assist the Practice in carrying out TPO.

I understand that I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I consent to the Practice's use and disclosure of my PHI as specified in the Privacy Policy and this Patient Consent for Use and Disclosure of Protected Health Information, I am also consenting to have my PHI and TPO shared with my Family, unless I have signed the an objection document. I understand that I may revoke my consent in writing, except to the extent that the Practice has already made disclosures in compliance with my prior consent. If I do not sign this consent, I understand that the Practice may decline to provide treatment to me.

X_____ _____

Signature of Patient or Legal Guardian **DATE**

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Many medical conditions require dilation in order to find and/or evaluate. An eye exam is not considered truly thorough without dilation. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist or optometrist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you make arrangements to not to drive yourself. An adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. I hereby authorize Regional Eye Associates, Inc. and/or such assistants as may be designated to perform drop instillation by the practice to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

X_____ _____

Signature of Patient or Legal Guardian **DATE**

Patient Name: _____ DOB: _____/_____/_____

MEDICAL CONDITIONS/DISEASES

☐ Acid Reflux	☐ Dementia	☐ High Blood Pressure	☐ Osteoporosis
☐ Anemia	☐ Depression	☐ High Cholesterol	☐ Prostate Problems
☐ Arthritis	☐ Diabetes	☐ Hyperthyroidism	☐ Sleep Apnea
☐ Asthma	☐ Fibromyalgia	☐ Hypothyroidism	☐ Stroke
☐ Atrial Fibrillation	☐ Hearing Loss	☐ Lupus	☐ Thyroid Disease
☐ COPD	☐ Heart Attack	☐ Migraine	☐ Tuberculosis
☐ Heart Disease	☐ Heart Murmur	☐ Obesity	☐ Ulcerative Colitis

☐ Cancer (please specify type): _____

Other: _____

PREVIOUS SURGERIES

	When

EYE DISEASES

☐ Cataracts	☐ Retinal Detachment	☐ Eye Injury	☐ Lazy Eye
☐ Glaucoma	☐ Macular Degeneration	☐ Dry Eye	☐ Diabetic Retinopathy

PREVIOUS EYE SURGERIES

	Eye	When?

FAMILY MEDICAL HISTORY

Condition	Yes	No	Who?	Condition	Yes	No	Who?
Glaucoma	☐	☐		Heart Disease	☐	☐	
Cataracts	☐	☐		Crossed Eyes	☐	☐	
Cancer	☐	☐		Blindness	☐	☐	
Diabetes	☐	☐		Retinal Detachment	☐	☐	
Stroke	☐	☐		Macular Degeneration	☐	☐	

SOCIAL HISTORY

Tobacco Use:	☐ Every Day Use	☐ Occasional Use	☐ Former User	☐ Never
Alcohol Use:	☐ Every Day Use	☐ Occasional Use	☐ Former User	☐ Never
Drug Use:	☐ Chronic Use	☐ Occasional Use	☐ Former User	☐ Never
Lives With:	☐ Spouse	☐ Alone	☐ Family	☐ Other:_____

Patient Name: _____ DOB: _____/_____/_____

CURRENT MEDICATIONS (add pages if needed)	Dosage	How many times daily?

Have you ever taken any of the following medications? (check all that apply)

☐ **Flomax** ☐ **Tamsulosin** ☐ **Uroxatrol** ☐ **Hytrin** ☐ **Cardura**

Have you ever had **any of the following?** (check all that apply)

☐ **Hepatitis** ☐ **MRSA** ☐ **Staph** ☐ **AIDS** ☐ **HIV**

ALLERGIES:

	Yes	No	Reaction:		Yes	No	Reaction:
Latex	☐	☐	_____	Gentamicin/Tobramycin	☐	☐	_____
Tape	☐	☐	_____	Keflex/Cephalosporins	☐	☐	_____
Penicillin	☐	☐	_____	Betadine/Iodine	☐	☐	_____
Vancomycin	☐	☐	_____	Anesthesia Medications	☐	☐	_____
Cipro	☐	☐	_____	Other (please specify drug & reaction):			_____
				_____			

REVIEW OF SYSTEMS: (check all that you are currently experiencing)

Cardiovascular	HEENT	Musculoskeletal	Respiratory	Blood Pressure
☐ chest pain	☐ dizziness	☐ back pain	☐ cough	☐ good BP control
☐ irregular heartbeat	☐ hearing loss	☐ joint pain	☐ trouble breathing	☐ borderline BP control
☐ shortness of breath	☐ hoarseness	☐ muscle aches	☐ wheezing	☐ poor BP control
	☐ ringing in ears	☐ stiffness		☐ unknown BP control
	☐ sore throat	☐ swelling		

Constitutional	Hematologic	Neurological	Skin	Diabetes Control
☐ fatigue	☐ bleeding	☐ balance problems	☐ hair loss	☐ good DM control
☐ fever	☐ bruising	☐ headache	☐ rash	☐ borderline DM control
☐ night sweats	☐ tender nodes	☐ numbness	☐ skin lesions	☐ poor DM control
☐ weakness		☐ tingling		☐ unknown DM control
☐ weight loss				

Genitourinary	Metabolic	Psychiatric	Allergy	Pregnancy
☐ genital discharge	☐ cold intolerance	☐ anxiety	☐ runny nose	☐ first trimester
☐ genital lesions	☐ excess hunger	☐ depression	☐ hives	☐ second trimester
☐ painful urination	☐ excess thirst	☐ insomnia	☐ itching	☐ third trimester
☐ urgency	☐ frequent urination	☐ irritability	☐ seasonal allergies	☐ not applicable
	☐ heat intolerance	☐ nervousness		

***Any additional issues:** _____

Patient Name: _____ DOB: _____/_____/_____