EyeCare 20/20
NEW PATIENT INFORMATION

PATIENT DEMOGRAPHICS

LAST NAME: _____ **FIRST NAME:** _____ **MIDDLE:** _____

SOCIAL SECURITY #: _____ **DATE OF BIRTH:** _____ **AGE:** _____ **SEX:** _____

ETHNICITY: _____ **RACE:** _____ **PREFFERRED LANGUAGE:** _____

HOME ADDRESS: _____ **CITY/STATE:** _____ **ZIP:** _____

CELL PHONE: ( ) _____ **HOME PHONE:** ( ) _____

E-MAIL ADDRESS: _____ **MARITAL STATUS:** _____

EMPLOYER/SCHOOL: _____ **OCCUPATION:** _____

FINANCIALLY RESPONSIBLE PARTY: _____ **PHONE:** _____

EMERGENCY CONTACT: _____ **RELATIONSHIP:** _____ **PHONE:** _____

PRIMARY CARE PHYSICIAN: _____ **CITY:** _____

HOW DID YOU HEAR ABOUT US? Family Friend Physician Internet TV Newspaper Magazine
Please circle all that apply.

Referred By: _____

PATIENT CONSENT TO RELEASE MEDICAL INFORMATION

I grant my permission to release and discuss all information, which includes appointments, medications, current medical statuses & treatment plans, billing and any other information pertinent to my medical care with the person(s) listed below:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Patient Signature: _____ **Date:** _____
If not signed by the patient, please indicate the name and relationship to the patient.

Name: _____ **Relationship:** _____

INSURANCE INFORMATION

We must receive a copy of ALL insurance cards at the time of service.

PRIMARY INSURANCE COMPANY: _____ **POLICY ID #:** _____

Name of Insured: _____ Date of Birth: _____

Relationship to Patient: _____

SECONDARY INSURANCE COMPANY: _____ **POLICY ID #:** _____

Name of Insured: _____ Date of Birth: _____

Relationship to Patient: _____

VISION INSURANCE PLAN: _____ **POLICY ID #:** _____

Name of Insured: _____ Relationship to Patient: _____

Are you currently enrolled in a Hospice Program? YES or NO

Eye Care 20/20's OFFICE POLICY, FINANCIAL ASSIGNMENT AND AGREEMENT: READ CAREFULLY AND SIGN

1. **PAYMENT IS EXPECTED AT EACH VISIT** If we are a participating provider for your health plan, we will file health insurance claims for you. It is **your responsibility** to provide our office with **accurate information** for billing your insurance plan properly at the time of service. It is also **your responsibility** to know whether there are multiple insurance carriers for your medical and vision insurance. For example, you may be covered under your primary healthcare for medical visits, however, there may also be additional vision care services under a different carrier. **It is your responsibility to know whether you have this separate coverage.**
   If at the time of service you only notify us of you primary healthcare plan and later make us aware of vision or other coverage under another plan, you will be responsible for any and all charges. We will provide you with an itemized reciept to submit to your insurance for reimbursement. We verify all vision and medical benefits prior to your visit, however the insurance company ultimately determines the coverage and reimbursements. In the event your insurance refuses full payment, you will be held personally responsible for the cost of the services provided.
   You will be responsible for paying any co-payments, coinsurance, deductibles and non-covered services at the time of the visit. Final payment responsibility will be determined upon receipt of correspondence from your insurance company. If we are NOT a participating provider for your health plan, you will be expected to pay in full at the time of the visit and you will be responsible for filing your own insurance claims.
2. Patient statements will be mailed monthly. Balances are due at the time the first statement is received. If no payments are received on your account after 3 billing cycles, a collection charge will be added and collection procedures will begin.
3. To avoid any potential misunderstandings, advise the receptionist should you need to make financial arrangements.
4. There will be a $20.00 charge on all checks returned unpaid due to insufficient funds.
5. All outstanding balances due by the patient must be paid before scheduling additional visits, procedures or surgeries.
6. **This office is NOT responsible for collecting on your insurance claim nor for settling a disputed claim.** Misunderstandings over insurance coverage and policy benefits are a matter to be resolved between the patient and their insurance company. We do not balance accounts according to "Reasonable and Customary" allowances established by insurance companies that we are not contracted with. Our services are coded according to the guidelines established by the AMA's Current Procedural Terminology (CPT). We will not code for reimbursement based on your insurance coverage.
7. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
8. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THIS POLICY AND AGREEMENT.

Patient or Authorized Signature	Name Printed	Date

PATIENT CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I understand that as part of the provision of healthcare services, EyeCare 20/20 creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing below, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

Patient or Authorized Signature	Patient's Name Printed	Date

EYE AND MEDICAL HISTORY

1. What is the **reason for your visit** today? _____

_____

2. Are you currently experiencing any of the following **eye symptoms**? Please circle all that apply.

Eye Pain **Blurred Vision** **Eyelid Crusting** **Flashes of Light** **Halos**

Discharge **Light Sensitivity** **Double Vision** **Decreased Vision** **Floaters**

3. Do you wear glasses? Yes No
4. Do you wear contact lenses? Yes No
5. Do you have problems reading? Yes No

6. Have you ever had an **eye injury**? If yes, please describe: _____

7. Have you ever had **eye surgery**? If yes, please list the type, which eye and the approximate dates.

_____

_____

8. Do you have a **family history** of any of the following eye problems? Please circle and list family relationship.

Glaucoma **Cataracts** **Retinal Disease** **Macular Degeneration**

9. Are you currently using any **eye medications**? If yes, please list the name and how often used._____

_____

10. What **medications** other than above are you taking? Please list._____

_____

11. Are you **allergic** to any medications? If yes, please list. _____

12. Are you being treated for any of the following medical conditions? Please circle all that apply.

Diabetes **Heart Disease** **High Blood Pressure** **Stroke** **Arthritis** **Other**_____

Do you currently have any of the following **problems**: Please circle **Yes** or **No** and If Yes, please explain.

Chronic fever, unexpected weight loss/gain, fatigue?	Yes	No	_____
Ear, nose, throat problems (hearing loss, sinus problems, sore throat)?	Yes	No	_____
Heart problems (chest pain, irregular heart beat)?	Yes	No	_____
Respiratory problems (shortness of breath, wheezing, coughing)?	Yes	No	_____
Gastrointestinal problems (heartburn, abdominal pain, diarrhea, vomitin	Yes	No	_____
Urinal problems (pain or discomfort, blood in urine)?	Yes	No	_____
Skin problems (rashes, excessive dryness)?	Yes	No	_____
Musculoskeletal problems (muscle aches, joint pain, swollen joints)?	Yes	No	_____
Neurological problems (numbness, weakness, headaches, paralysis)?	Yes	No	_____
Psychiatric problems (depression, anxiety)?	Yes	No	_____

Do you smoke?_____ If Yes, how much? _____ Do you drink alcohol?_____ How much? _____
If employed, how many hours per week do you work?_____ hours per week

Patient Signature: _____ ***Date:*** _____

EyeCare 20/20
Financial Policy

We are dedicated to providing the best possible care and service to you and your family. We feel that your understanding of our financial policy is an essential component of your care and treatment. If you have any questions, please do not hesitate to ask our staff.

VISION vs. MEDICAL INSURANCE

It is **your responsibility** to provide our office with accurate information for billing your insurance plan properly at the time of service. It is also **your responsibility** to know whether there are multiple insurance carriers for your medical and vision insurance. For example your may be covered under your primary healthcare plan for medical visits, however there may also be additional vision care services under a different carrier. **It is your responsibility to know whether you have this separate coverage.**

If at the time of service you only notify us of your primary healthcare plan and later make us aware of vision coverage under another plan, you will be responsible for any and all charges. We will gladly provide you with an itemized receipt to submit to your insurance for reimbursement. We verify all vision and medical benefits prior to your visit, however the insurance company ultimately determines the coverage and reimbursements. In the event your insurance refuses full payment, you will be held personally responsible for the cost of the services/items provided.

ROUTINE vs. MEDICAL EYE EXAMS

Our office participates with certain vision plans for "routine eye exams." A routine eye exam is, by definition, a "regular check-up" for someone with no eye problems who just needs glasses or contact lenses. If the doctor detects any medical condition (dry eyes, floaters, etc.) the exam may become a medical eye exam and will be submitted to your medical insurance. If your insurance plan requires a referral, you will need to obtain one for the exam. Due to insurance company regulations, routine and medical exams may not be performed on the same day. Please note that some insurance plans consider a routine eye exam to be a non-covered service.

SPECTACLE vs. CONTACT LENS EXAMS

The exam for spectacles and contact lenses are **separate** exams. If you desire a contact lens evaluation, you will be charged a fee for this service. If we submit the claim to your insurance company and it is determined to be a "non-covered" service or you're not eligible at the time of service, you will be responsible for this charge.

AMOUNTS DUE FROM THE PATIENT

We gladly accept cash, personal checks, and most major credit cards. Insurance co-payments will be collected at the time of service. If we do not participate with your insurance plan, you are to provide payment in full at the time of service. We will provide you with an itemized statement of services and amounts paid which you may submit to your insurance. Your insurance is then responsible for reimbursing you.

SERVICES DETERMINED "NOT COVERED"

In the event a health plan determines a service/item of ours to be 'not covered," you will then be responsible for the complete charge. An important example of this is when we check your eyes for changes in the prescription (a procedure called refraction). We charge for this service and many insurers, including Medicare, deem this service as "not covered."

I have read and understand the financial policies of EyeCare 20/20 and also understand that EyeCare 20/20 reserves the right to change any and all fees at any time.

_____ _____

Signature of Patient (or Responsible Party if Patient is a Minor) **Date**

EyeCare 20/20
Retina & Vision Center

Dr. Neil F. Notaroberto, M.D.
Dr. Arley G. Jaramillo, M.D.
Dr. Jaime W. Wang, O.D.

Harahan - Mandeville - Slidell
1-800-680-EyeCare
www.EyeCare2020.org

DILATION CONSENT

Dilating drops are placed in your eyes to dilate or enlarge the pupils of the eye to allow doctor to get a better view of the inside of your eye.

Dilating eye drops cause a variable amount of blurred vision for an unpredictable length of time. It is not possible for your eye doctor to predict how much your vision will be affected and for how long. This varies from person to person and may make bright lights bothersome. When having your eyes dilated, you should bring sunglasses with you to minimize glare and light sensitivity when you leave your appointment. Your doctor can provide one-use sunglasses if needed. Since driving may be difficult after examination, it is best if you make arrangements to not 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.

PATIENT ACKNOWLEDGEMENT

I hereby authorize the doctor and/or such assistants as may be designated by him/her to administer dilating eye drops as the eye drops are necessary to diagnose my condition.

Patient Signature _____ Date _____

EyeCare 20/20 Retina & Vision Center

APPOINTMENT CANCELLATION/NO SHOW POLICY

When you schedule an appointment with our office we schedule enough time and personnel to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, with at least 24 hours notice prior to your scheduled appointment. This gives us time to schedule other patients who are waiting for an appointment.

Please see our Appointment Cancellation/No Show Policy below:

- ✦ Any patient who fails to show for or cancels/reschedules an appointment and has not contacted our office with at least 24 hours notice will be considered a No Show and charged a $50.00 fee. This is a fee that is charged to the patient and not the insurance company.

- ✦ If a third failure to show or a cancellation/reschedule without 24 hour notice should occur, the patient may be dismissed from our practice.

- ✦ As a courtesy, we send out text message reminders and make calls for appointments a day or two in advance. If you do not receive a reminder call or message, the above Policy will remain in effect. We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our Office Manager. You may contact our office 24 hours a day, 7 days a week. If it is after regular business hours Monday through Friday, or on a weekend, you may leave a message.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

Print Name _____ Date _____

Signature _____