PATIENT INFORMATION PACKET

Today's Date: ________________________ **Account #**:________________

Patient Name: ____
First Middle Last

Date of Birth: ___________________ **Male** _____ **Female** _______ **Social Security**: ____________________________

Address: ___________________________________ **City**:____________________ **State**: ____________ **Zip**: _________

Home Phone: _____________________ **Daytime Phone**: _____________________ **Mobile Phone**: _________________

Emergency Contact Name: ____ **Phone**: _____________________
First Last

Primary Care Doctor: ____ **Phone:** ____________________

Email: _________________________________ **Martial Status**: Single ____ Married ____Divorced____ Widowed ____

PATIENT OR RESPONSIBLE PERSON'S EMPLOYMENT INFORMATION

Occupation: ____ **Phone:** ____________________

Employer:______________________________________ **Work Phone:**____

Work Address:______________________________________**City:**____________**State:**________________**Zip:**_______

GUARANTOR INFORMATION

Guarantors Name: ____
First Middle Last

Address: ___________________________________ **City**:____________________ **State**: ____________ **Zip**: _________

Phone: _________________ **Relationship to Patient**: ____________________

INSURANCE INFORMATION

Primary Insurance Company:			
Subscriber Name:	ID#		Group #
Relationship to Patient:	SSN		DOB
Secondary Insurance Company:			
Subscriber Name:	ID#		Group #
Relationship to Patient:	SSN		DOB
Vision Plans:			
Subscriber Name:	SSN	ID#	DOB

Financial Statement and Agreement

- Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay for fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co- payment, co-insurance, or any other balances not paid by your insurance. If you do not have insurance, we request that your charges be paid in full at the time of your exam. **If you have insurance your co-pay/ deductible must be paid in full at the time of your visit.** If we have not received your payment after three statements, a statement fee charge will be added.

- **The refraction examination is $ 35.00 and is considered a non-covered service by Medicare. The refraction fee is collected at the time of your visit.** Refraction is performed for New Patient exams, complete exams, and whenever a patient's vision is less than 20/20. **WHAT IS A REFRACTION?** Refraction is the examination process to determine your eyes refractive error, or need for corrective lenses. The term "refraction" refers to how light waves are bent as they pass through your eyes cornea and lens.

- If at any time you are unable to keep your appointment, we would appreciate a call 24 to 48 hours during our business hours, so that we may cancel your appointment and use the appointment time for another patient. If the appointment is canceled the day of or missed, you will be charged a $50 non-cancellation fee.

- Patients who have their account in collection are responsible for **35 % of the collection fee** in addition to the balance due on their account.

I request that payment of authorized Medicare and/ or insurance benefits be made on my behalf for any services furnished.

I authorize any holder of medical insurance about me to be released to the Health Care Financing Administration, its agents, or any insurance carries I may have, any information needed to determine these benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize release all information necessary to secure the payment.

Signature of Patient/ Guarantor ______________________________ Date ______________________

Authorization to Release Information and Assignment of Benefits

1. I authorize the release of any information necessary for treatment, payment and health care operations; this includes Primary Care Physician and/ or referring physician. I also permit that a copy of this authorization to be used in the place of the original. **Your medical and financial reports can be mailed and/or faxed to you or authorized person.**

Signature of patient/ Guarantor ______________________________ Date ________________

2. If there is someone you authorize the office to discuss your medical records, not limited to spouse, parent or legal guardian, please write their name on the line below.

Name:______________________Relationship:____________Phone Number:______________

3. I have received and/or was offered a copy of the **HIPAA NOTICE OF PRIVACY PRACTICE.**
   Initials ____________

MEDICAL INFORMATION

- **Last Eye Exam:** _________
- **Medication Allergies** : No ___ Yes ___**Please list**____
- **List all medications (includingeye drops)**

1	2	3
4	5	6
7	8	9

- **Do you wear contact lenses?** Yes ___ No ___
- **Do you wear glasses?** Yes ___ No ___
- **Are you interested in getting contact lenses?** Yes___ No___
- **Have you had Lasik surgery?** Yes ___ No ___
- **Are you interested in Lasik surgery?** Yes ___ No ___

- **Please list any surgeries:** ____

<u>Do you have any current or past medical history?</u> Please Check all that Apply,

Diabetes __	High Blood Pressure ___	Heart Disease__	Stroke___	Heart Attack__	High Cholesterol__	Cancer ___
List any other:						

<u>Do you have any of the following conditions?</u> Please Check All that Apply

Glaucoma ___	Cataracts ___	Dryness ___	Eye Burning ___	Retinal Disease ___	
Itching ___	Irritation ___	Eye pain ___	Loss of Vision___	Light Sensitivity ___	Macular Degeneration ___
Lazy eye ___	Tearing ___	Foreign Body ___	Mucous / Film ___	Drooping eyelids ___	
Blurriness ___	Crossed eye ___	Pregnancy___	Distorted Vision___	Flashes/Floaters ___	Infection of eye/eyelids __

Other: ____

<u>Social History</u>

- **Do you drive?** Yes ___ No ___
- **Do you smoke?** Yes ___ No ___ **Pack(s) per day:** ______
- **Do you drink alcohol?** Yes ___ No ___ Occasional___ Moderate___ Heavy Drinker___
- **Have you ever had a blood transfusion?** Yes ___ No ___

Family History: Please indicate relationship- F- father M- mother S- sibling Grandparent- GP

Blindness _____	Heart Disease _______	Stroke _______	Glaucoma _______	High Blood Pressure _____
Cancer _______	Diabetes _______	Lupus _______	Kidney Disease _______	High Cholesterol _______

Please mark the box if you need accommodations for hearing impairment { }

<u>PRINT PATIENT NAME:</u>____

Routine Eye Exams vs. Medical Eye Exams

Please Read **Before** Your Eye Examination

Regular eye examinations are important to maintain your vision for your lifetime. It is important that you be aware of your insurance benefits and how they apply to your visit, so you will know how billing will be handled. Ultimately, it is your responsibility to know what your own insurance plan covers. Some medical insurance plans provide a benefit for one routine, preventive eye examination per year. We hope this information will help you to understand how your visit is submitted to your insurance for today's visit and future visits with Maryland Eye Institute.

Benefits may vary based upon the reason for your visit. Your description of your eye condition will help us to determine whether your visit to the clinic is defined as "Routine" or "Medical". Your symptoms and eye examination findings will determine how your visit is coded and billed to your insurance.

Initial____ Routine Eye Examinations A "routine eye exam" takes place when you come for an eye examination without any medical eye problem. The doctor screens the eyes for disease and will check your vision. **This DOES NOT include a contact lens exam.**

It is your responsibility to tell us what insurance benefit you intend to use. Please be informed that if you report symptoms during your visit related to an eye problem, disease, or injury, or your doctor determines that your problem falls under the category of a "medical eye examination", your visit will be billed as a *medical* exam instead of a *routine* exam, which will be subject to co-pays and deductibles according to your plan.

Initial____ Medical Eye Examinations Exams for medical care which are for evaluation of a medical-related complaint or follow up of an existing condition are examples of an eye examination that would be billed to your medical insurance. Examples that will necessitate your visit being submitted as a medical exam include diabetes mellitus, eye irritation, dry eyes, allergies, floaters, glaucoma, cataract, eye muscle imbalance, "lazy eye", macular degeneration, and others. Please note that if you have diabetes mellitus, and would like us to send a letter to your primary care physician regarding your eye examination, the visit will be coded as a "medical eye examination". **This DOES NOT include a contact lens exam.**

In summary, how your eye exam will be submitted to your insurance carrier will depend not only upon what you tell the doctor, but also what the doctor finds upon examination. Your signature below indicates that you understand the differences between routine and medical eye examinations and the potential implications of these differences on the type of exam that gets billed and the potential for fees that may include co-pays, deductibles, and/or co-insurance fees. You understand that you are responsible for any of these fees as determined by your insurance carrier. If you have any questions, please ask a member of our staff.

_______________________________ _______________________________

Patient Signature **Date**

PRINT NAME____

Our Office Policies

REFERRAL POLICY

- Patients whose insurance requires a referral must have a valid and current referral from their primary care doctor in order to be seen. Your appointment will be rescheduled if the proper electronic or paper referral is not present. If you choose to be seen without obtaining the proper referral, you must sign an insurance waiver and payment in full is expected in full at the time of the visit.

MISSED APPOINTMENTS POLICY

- There is a $50.00 charge for missed appointments, unless canceled at least 24 hours prior to your appointment. This fee must be paid prior to your next visit.

ADDITIONAL FEES

- Copying of medical records: $0.76 cents per page plus any postage/ shipping if applicable.

COLLECTION FEES

- If for some reason you fail to pay your account balance in a timely manner and the balance is sent to our collection agency then **you will be responsible for the collection fees of 35% and any other legal fees associated with the collection process.**

CHILDREN POLICY

- No children or siblings can accompany a patient during his/her visit.

POLICY REGARDING DEDUCTIBLES

- Our office collects $150.00 on each visit, towards the insurance yearly deductible, until the insured deductible has been met for the insurance policy year, excluding Medicaid patients. The collection of $150.00 is just **a portion** of the balance; Please be aware that **a bill may still be sent out** after the Explanation of Benefits has been received from the insurance. Besides collection of $150.00 towards the deductible, the practice **will also collect the copayment, if applicable**, at each visit. Please note that the patient is also **responsible for any coinsurance, if applicable**.

By signing below, you are indicating that you have read and understood the policies as they are written above:

Signature of Patient ___________________________ Date________________________

Print Name____

Your Comprehensive Eye Exam

Your comprehensive exam may take up to **2 hours** which includes the use of dilating drops. These medicated eye drops enlarge your pupil so your doctor can get a better view of the internal structures in the back of the eye. **Dilating drops usually take about 20 minutes to start working.** When your pupils are dilated, you will be sensitive to light, because more light is getting into your eye. You may also notice difficulty reading or focusing on close objects. These effects can last for up to several hours, depending on the strength of the drops used.

If you don't have sunglasses to wear after the exam, disposable sunglasses will be provided to help you drive home. Dilation is very important for people with risk factors for eye disease, because it allows for a more thorough evaluation of the health of the inside of your eyes.

Depending on your particular needs, your eye doctor may perform additional tests immediately or schedule another appointment to be performed at a later date.