PATIENT REGISTRATION

Name:_____ Sex :□ M □ F Date of Birth:_____/_____/_____ Age:_____

SS#_____ Email:_____ Marital Status: □ Single □ Married □Widowed □ Divorced

Address_____City _____ State_____Zip_____

Home Phone: (_____)_____-_____Cell: (_____)_____-_____ How would you like appointment reminders? □ Call □ Text (_____)_____-_____

Employer:_____Occupation _____

Primary Care Dr:_____ Referring /Specialty Dr._____

Emergency Contact Name:_____Relationship: _____

Emergency Contact Address :_____ Emergency Contact Phone #: _____

_____

Language: □ English □ Vietnamese □ Spanish □ Russian □ Other

Race: □ American Indian /Alaska Native □ Asian
□ White □ Black/African American □ Other

Ethnicity: □ Hispanic □ Not Hispanic

NOTICE OF PRIVACY PRACTICE

My medical information can be shared with: _____

Relationship: _____

Address: _____ Phone #: _____

_____

I acknowledge that I have received and reviewed a copy of the "Notice of Privacy Practices" which describes how Eyesight and Surgery Associates may use and disclose my healthcare information and how I can gain access to my information

signature _____Relation to Patient: _____ Date:_____

INFORMATION AND CONSENT FOR PUPIL DILATION

Pupil Dilation is essential for full medical evaluation of the eye. This requires the placement of multiple eye drops. Dilation causes an inability to focus on near objects or reading material, which can make close work very difficult. It may cause difficulty driving or operating heavy machinery. Dilation may also cause some unsteadiness in walking. Please ask for assistance if you feel uncomfortable. These side effects can last for several hours afterward.

Very rarely, dilation of the pupils can induce a type of glaucoma in people who are susceptible to this problem. We check for signs that you might be predisposed to this type of glaucoma prior to receiving dilation drops. Signs of acute glaucoma include redness, severe pain, nausea, loss of vision. If any of these occur after dilation, you should call the office immediately.

I give my consent for pupil dilation during any and all of my visits to this office if it is necessary.

Consent _____ Relation to Patient:_____ Date:_____/_____/ _____

OR

I refuse dilation knowing that my exam will be less comprehensive.

Refuse _____ Relation to Patient: _____Date:_____/_____/_____

Eye Exam & Office Policies

Routine Eye Exam A general screening of overall eye health with no medical problems or complaints.

Medical Eye Exam An exam where you are being evaluated for and/ or treated for a medical condition or symptom that you describe to our staff, or a condition that the doctor finds during the examination. Examples include: *headache, diabetes, eye irritation, dry eyes, allergies, contact lens intolerance, glaucoma, cataract, macular degeneration, etc.*

Vision Plan/Benefit Typical coverage includes an eye exam once every 12-24 months. This benefit is only used for a routine exam and not to treat any medical eye issues. If the doctor identifies an eye problem, disease, or injury, your visit will be billed to your medical insurance. You will be able to use the routine benefit at another visit.

Contact Lens Exam Contact lens exams have a fee associated with them, in addition to the exam fee.

Refraction This test provides information about the function of your eyes and may alert the doctors of any problems that may be related to a decrease in your vision. This test is also necessary if you wish to get an updated eyeglass or contact lens prescription. If you do not have routine exam coverage or a separate vision plan, or if your plan does not cover this service, you are responsible for this fee in addition to your other insurance policy fees.

This $50 fee is due at the time of your visit.

Insurance You authorize the payments of insurance benefits be made your behalf directly to Eyesight & Surgery Associates for any service provided to you there. You authorize release of any medical information necessary to determine those benefits. You are responsible to notify our office of any changes with your address, phone number, or insurance information. It is your responsibility to know the details of your plan, including deductibles, co-payments, and vision coverage.

Financial Agreement You are financially responsible for any charges for services provided. If you have out of network benefits and the provider is out of network, you are responsible for higher co-insurance, deductibles, and co-payments. If you choose to have non-covered services performed, you are responsible for the full fee. If your account is sent to collections for lack of payment, you are responsible for payment of your provider's expenses incurred to collect the past due amount, including without limitation, attorney's fees.

Referrals You are responsible for obtaining your insurance referrals, as required by your insurance policy. If your insurance denies your visit, you will be responsible for unpaid balances. It is you responsibility to know if your policy requires a referral.

Co-payments Co-payments are due at the time of the visit.

If you ask to be billed, there will be an additional $5.00 fee.

Returned Checks There is a **$25.00 fee** for all returned checks, for each occurrence. We reserve the right to no longer accept checks as form of payment from any person whose check does not clear. Checks that are returned for closed accounts will be reported to the authorities.

Missed Appointments We require that you call our office at least **24 hours** prior to your appointment if you need to cancel /reschedule an appointment**.** We may discharge you from the practice for multiple missed appointments.

There is a $20 fee for any appointments you miss without providing notice which must be paid before scheduling another appointment.

I have read, understand, and will abide by all the policies.
I also understand that my symptoms and doctor's findings during my exam determine how my exam is billed to insurance. If I do not provide routine insurance information at my visit, my exam will be billed to medical insurance and cannot be rebilled.

Signature _____ Relation to Patient: _____ Date:_____