



Patient Demographic

Date: _____
Name: _____
Date of Birth: _____ Age: _____ Sex: _____
Address: _____
Home phone: _____
Cell phone: _____
Email: _____
Occupation: _____ Employer: _____

Insurance

Guarantor: Who is responsible for this account? _____ Relationship: _____
Insurance Medical : ID#:
Insurance Vision: ID#:

Referral Information

How did you find out about our office?

- Insurance: (Name of insurance co.) _____
- Friend/Patient: (Name so we may thank them) _____
- Doctor: (Name of referring Dr.) _____
- Internet/Website
- Drive by
- Other: _____

Patient Consent: HIPAA

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected 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

By signing this document, I have been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*. The *Notice of Privacy Practices* contains 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 Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

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 by such restrictions.

Name: _____
Date: _____
Signature: _____



Patient Name:

Payment Policies and Procedures:

- ❖ As a courtesy to our patients we will be happy to file your insurance for you. In the event that your insurance company does not pay for your bill, you acknowledge that you are ultimately responsible for the payment of all usual and customary fees. There are many different insurance plans available and all plans vary based on premiums, employers, etc. Although we have a broad knowledge on *most* insurance plans, it is ultimately your responsibility to know your individual plan and what it covers before your visit.
- ❖ Accounts 90 days old are subject to collection fees.
- ❖ There will be a \$25.00 service charge on all returned checks. All co pays and material costs not covered by your insurance are due at the date of service.
- ❖ Our cancellation fee is \$30.00 for a missed or cancelled appointment without providing a 24 hr. notice

Patient Acknowledgement Regarding Contact Lens Evaluation and Refraction Fee (if applicable):

Contact lens patients require additional testing and monitoring over and above what is done in a routine eye examination. This monitoring includes:

- a microscopic assessment of the contact lens on the eye to check the appropriateness of the lens fit,
- a microscopic examination of the cornea to inspect for adverse effects from contact lens wear such as oxygen deprivation
- a contact lens refraction to determine the correct contact lens prescription power
- a review of any new lens design and/or materials that may improve comfort and eye health.

There is an additional fee for this service (over and above the fee for a routine eye exam), which varies depending on a number of factors including the complexity of the prescription and the need for follow-up visits. Most vision plans do not cover this additional professional fee. Payment of the contact lens evaluation must be paid in full before contact lenses can be dispensed.

A "Refraction" includes the testing to determine a person's need for glasses. This test is not covered by Medicare or most **medical insurance plans**. However, it is covered by **vision plans**.

If your diagnosis is medical in nature (such as cataract, dry eye, glaucoma, etc), then your exam could be billed to your medical insurance. If you would also like to have your vision prescription checked and updated, a refraction must be performed. The fee for this service is an additional \$25 and is collected at the time of service. We will not file the charge for a refraction with a medical insurance plan unless we know that the plan covers a refraction. Should your plan pay us for the refraction, we will reimburse you accordingly.

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to rendering care in this practice, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

I have read all of the above and agree with Caris Eye Centers policy and procedures regarding my patient account. I have read and understand the above information. I accept full financial responsibility for the cost of refraction and/or contact lens evaluation **if provided** and if not covered by my insurance. I understand that any co-payment or deductible would be separate from and not included in either the refraction or contact lens fee.

Name:

Date: _____

Signature: _____



Patient Name:

REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem, or our patient who we haven't seen for a while, we need to update our records as to general medical health problems that might result in eye problems. In each area, if you are not having any difficulties, please check "No Problems". If you are experiencing any of the symptoms listed, **PLEASE CHECK THE ONES THAT APPLY** or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

- GENERAL HEALTH** No Problems Lack of Energy Jaw Pain when chewing Scalp Tenderness
 Other _____
- EAR, NOSE, THROAT** No Problems Hearing Loss Sinus Congestion Dry Mouth
 Other _____
- HEART** No Problems Irregular Heart Beat Chest Pain Palpitations
 Other _____
- LUNGS/BREATHING** No Problems Coughing Wheezing Shortness of breath
 Other _____
- STOMACH/INTEST** No Problems Heartburn Nausea Food Intolerance
 Other _____
- MUSCLE/JOINT** No Problems Joint pain Back pain Stiffness
 Other _____
- SKIN** No Problems Rash Melanoma Dry Skin
 Other _____
- NEUROLOGIC** No Problems Frequent Headaches Dizziness Double Vision
 Other _____
- MENTAL STATE** No Problems Stress Insomnia
 Other _____
- GLANDS** No Problems Heat/Cold Intolerance Excessive Thirst
 Other _____
- BLOOD** No Problems Bleed Easily Bruise Easily Abnormal Blood Tests
 Other _____
- IMMUNE SYSTEM** No Problems Seasonal Allergies Hayfever Hives
 Other _____

Patient Name:

MEDICAL HISTORY

Please mark "YES" if you or any immediate family member (parents or siblings) have had any of the following:

	Yourself	Family Member		Yourself	FamilyMember
AIDS/HIV	<input type="checkbox"/> YES	<input type="checkbox"/> YES	Hypertension	<input type="checkbox"/> YES	<input type="checkbox"/> YES
Arthritis	<input type="checkbox"/> YES	<input type="checkbox"/> YES	Thyroid Disease	<input type="checkbox"/> YES	<input type="checkbox"/> YES
Asthma	<input type="checkbox"/> YES	<input type="checkbox"/> YES	Blindness	<input type="checkbox"/> YES	<input type="checkbox"/> YES
Cancer	<input type="checkbox"/> YES	<input type="checkbox"/> YES	Cataracts	<input type="checkbox"/> YES	<input type="checkbox"/> YES
COPD	<input type="checkbox"/> YES	<input type="checkbox"/> YES	Crossed Eyes	<input type="checkbox"/> YES	<input type="checkbox"/> YES
Depression	<input type="checkbox"/> YES	<input type="checkbox"/> YES	Glaucoma	<input type="checkbox"/> YES	<input type="checkbox"/> YES
Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> YES	Macular Degeneration	<input type="checkbox"/> YES	<input type="checkbox"/> YES
Elevated Cholesterol	<input type="checkbox"/> YES	<input type="checkbox"/> YES	Retinal Detachment	<input type="checkbox"/> YES	<input type="checkbox"/> YES
Irregular Heartbeat	<input type="checkbox"/> YES	<input type="checkbox"/> YES	Retinal Disease	<input type="checkbox"/> YES	<input type="checkbox"/> YES
Drug Allergies	<input type="checkbox"/> YES	<input type="checkbox"/> YES Please list Allergies: _____			

SURGICAL HISTORY

Please mark "YES" if you have had any of the following surgeries:

Eyelid Surgery	<input type="checkbox"/> YES	Eye Muscle Surgery	<input type="checkbox"/> YES
Cataract Surgery	<input type="checkbox"/> YES	LASIK or PRK	<input type="checkbox"/> YES
Corneal Surgery	<input type="checkbox"/> YES	Radial Keratometry (RK)	<input type="checkbox"/> YES
Other Eye Surgery	<input type="checkbox"/> YES _____		

SOCIAL HISTORY

Smoking Status Never Smoked Former Smoker Current Smoker
Alcohol use Never Less than 1 drink per day 1-2 drinks per day 3 or more per day

MEDICATIONS

Please list all prescription medications that you are currently taking along with any non-prescription eye drops that you currently use on a regular basis.

Medication:

Reason:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please circle:

Do you currently wear glasses? **Yes** or **No**
Do you currently wear contact lenses? **Yes** or **No**



Eye Exam

Routine vs Medical

As part of health care reform in the United States, there are now more specific guidelines, implemented by the insurance industry used to determine whether an eye exam is considered “Routine” or “Medical”. This classification is important because it determines whether we should submit the claim to the Medical Insurance Provider or the Vision Plan.

There are specific instances when we are contractually obligated to submit the claim to the patient’s Medical Insurance rather than their Vision Plan.

Routine Eye Exam Defined – An eye exam is classified as “Routine” when there is no medical eye problem and there are *no symptoms* other than vision changes that can be corrected by glasses or contact lenses. Vision plans will only accept a claim that has a primary diagnosis such as myopia (nearsighted), hyperopia (farsighted) etc. **Refraction** (the determination of your eyeglass prescription) is included with all vision plans.

Medical Eye Exam Defined – An eye exam is considered “Medical” based on several factors. The primary factors are:

- The existence of a pre-existing medical condition that carries risk of eye complication. Some examples are diabetes, retinal degeneration, cataracts, etc.
- The patient’s stated reason for their visit. An example of this would be “my eyes are red”.
- A primary diagnosis that is medical in nature. This could be either a pre-existing medical condition or a new medical diagnosis that requires a treatment plan. An example of this would be a diagnosis of “dry eye” and the treatment plan could be as simple as “artificial tears”

Refraction (the determination of your eyeglass prescription) is NOT included with medical insurance plans. At Caris Eye Centers, we charge \$25 for this component of an eye exam.

For Patients with BOTH Medical and Vision Coverage

If you are being evaluated for medical reasons (cataracts, dry eye, diabetes, glaucoma risk, double vision, etc) we will file the claim to your medical insurance. You may still use your Vision Plan benefit for your glasses or contact lenses if applicable.

In Summary – The determination as to whether an eye exam is classified as “Routine” or “Medical” is not subjective and is not made by the doctor nor the patient. It is defined by the insurance industry based on the criteria listed above.

Patient Acknowledgement:

I have read and understand the above explanation and policy:

Patient Signature _____

Date _____



Retinal Health Evaluation Consent

Most patients would agree that the only unpleasant aspect of eye exam is having their eyes dilated. However, inspecting the retina for potential sight threatening eye disease is a critical component of a comprehensive eye exam.

At Caris Eye Centers, we are pleased to offer a new technology to our patients, **Optomap Ultra-widefield Retinal Imaging**. This instrument captures a digital scan of the the retina in less than one second. There are no dilation drops necessary and therefore, no side effects. In most cases, this scan eliminates the need to dilate the patient's pupils.

The fee for an Optomap retinal scan is \$39 and is not covered by vision plans. Please inform us of your preference below.

<div data-bbox="272 961 678 1066" style="text-align: center;">Option 1 Optomap Retinal Imaging</div> <ul data-bbox="256 1144 734 1318" style="list-style-type: none">• Provides a permanent picture of the retina for future comparison• No dilation drops necessary• No visual side effects• Less time in the office	<div data-bbox="912 961 1318 1066" style="text-align: center;">Option 2 Dilation Drops</div> <ul data-bbox="889 1108 1393 1432" style="list-style-type: none">• Dilation involves instilling eye drops to enlarge the pupils to obtain a wider view of the back of the eyes.• Allow an additional 20-30 minutes for your eye exam today• Side Effects:<ol data-bbox="982 1327 1334 1432" style="list-style-type: none">1. Blurry Near Vision for 3-6 hours2. Light sensitivity for 3-6 hours
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I prefer Optomap ultra-wideview retinal imaging today.

I decline the option of Optomap retinal imaging and I agree to dilation drops if recommended.

Signature of patient (parent or guardian if minor)

Print Name

Date