

East Ridge Eye Center

Date _____ Referred by _____

Full Name _____ SS#: _____

Address _____ City _____ State _____ Zip _____

Home Ph _____ Work Ph _____ Cell Ph _____ AGE _____

Email address _____ May we contact you via email regarding balances, lab/test results, appointment reminders, etc? If yes, sign here _____

If no, sign here _____

Date of Birth ____/____/____ Marital Status _____ Sex: M F

Employer _____

Complete Address _____

Spouse or Domestic Partner Information

Full Name _____ SS# _____

Date of Birth ____/____/____ Work Ph _____ Cell Ph _____

Employer _____

Employer Address _____

In Case of Emergency, please notify _____ Relationship _____

Address _____ Phone _____

General Consent for Treatment:

We need your permission for our physician to examine you, provide treatments, and perform diagnostic studies as necessary. If more invasive procedures are deemed necessary, the risks & benefits of those invasive treatments will be explained to you. When you agree to proceed with an invasive treatment, you will be asked to sign a more detailed consent.

*I give general consent to be treated by East Ridge Eye Center.

Signature _____ Date _____

Financial Policy/Assignment of Benefits/Promise to Pay

I hereby authorize East Ridge Eye Center., to release to my insurance carrier(s) any information required to process insurance claims on my behalf.

Promise to Pay: I agree to be responsible for payment for professional services rendered to me or on my behalf by East Ridge Eye Center. If this promise to pay is collected by an attorney, by suit or otherwise, I agree to pay all attorneys' fees, interest at the legal rate, and all costs of collection. I understand that payment is due at the time services are rendered unless other arrangements are made, including, but not limited to, deductible, co-pays and co-insurance.

Signature _____ Date _____

*****IF PATIENT IS A MINOR PLEASE FILL OUT BACK OF FORM*****

MINOR'S INFORMATION

Father's Information

Full Name _____
Address (if different from minor child) _____
Home Phone _____ Date of birth ____/____/____ SS# _____
Employer _____
Address _____
Work Phone _____ ext _____

Mother's Information

Full Name _____
Address (if different from minor child) _____
Home Phone _____ Date of birth ____/____/____ SS# _____
Employer _____
Address _____
Work Phone _____ ext _____

Legal Guardian Information (if applicable) Relationship to patient _____

Full Name _____
Address _____
Home Phone _____ Date of birth ____/____/____ SS# _____
Employer _____
Address _____
Work Phone _____ ext _____

NOTICE OF FINANCIAL RESPONSIBILITY:

Please be aware that whoever accompanies the minor child and signs the Financial Policy/Assignment of Benefits/Promise to Pay (located on the other side of this form) assumes financial responsibility for this minor patient for all services rendered, regardless of whether or not you are normally financially responsible for this minor.

I understand that I am financially responsible for any and all services rendered by East Ridge Eye Center on behalf of this minor child.

Signature of Responsible Party Date

Relationship to Minor Patient

Name of Person(s) Accompanying Minor Today (please print): Relationship to Minor:

Patient Name: _____

_____ I hereby give permission for the staff of East Ridge Eye Center to discuss any of my past, present or future information including but not limited to medical, financial, insurance, personal or any other matters with the following designated person(s):

Person:

Relationship:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient Signature

Date

Witness

_____ I do not give permission for any information to be made available at this time.

Patient Signature

Date

Witness

Dilated Eye Exam

In order to perform a complete ocular examination, your eyes will be dilated. Dilation is accomplished by placing drops in your eyes.

Dilation will make the pupils large so the doctor can visualize the optic nerves and peripheral retina more clearly.

Dilation will last approximately 6-8 hours on an adult, and up to 24 hours on a child dependent upon the drops needed and used.

Your eyes will be more sensitive to bright light and your near vision will be blurred. Sunglasses are recommended. The office will supply disposable sunglasses for your convenience.

If you need an excuse for work/school, one will be provided to you upon request. The excuse will state the time you were here and will release you to return to work/school the same day.

Please direct any questions to the technician that works with you during your appointment.

Thank you for choosing East Ridge Eye Center for the care of your eyes.

Patient Signature

Date

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Date of **birth**: _____ Date of **last eye exam**: _____

Are you pregnant or is there any possibility you could be pregnant? Yes No

List any **medications** you currently take (prescription and over-the-counter):

Do you have **allergies** to any medications? Yes No

If YES, list the medications:

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):

List any **surgeries** you have had (cataract, tonsillectomy, appendectomy):

Do you *currently* have any problems in the following area? If "YES", please provide information.

	Yes	No	Explanation of Problem
EYES (Glaucoma, cataract, retinal disease, etc.)			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
GENERAL/CONSTITUTIONAL			
Fever			
Weight loss			
Other			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			

Name: _____ Date: _____

Date of birth: _____

Do you *currently* have any problems in the following area? If "YES", please provide information.

	Yes	No	Explanation of Problem
CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple sclerosis, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (Cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, Lupus, Sjogrens, etc.)			

FAMILY HISTORY

M=mother F=father S=sibling GP=grandparent

DISEASE	Yes	No	RELATIONSHIP TO PATIENT
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current occupation: _____

Education (high school, vocational school, college degree): _____

Marital Status (married, divorced, single, widowed): _____

Living arrangements: _____

Do you drive? Yes No

Do you have visual difficulty when driving? Yes No

Do you have problems with night vision? Yes No

Have you ever tried to wear contact lenses? Yes No

Do you currently wear contact lenses? Yes No

If YES, how long have you worn contact lenses?

Do you currently wear glasses? Yes No

If YES, how long have you had your current prescription?

Do you drink alcohol? Yes No If "YES": occasional 1 per day 2-3 per day 4+ per day

Do you smoke? Yes No If "YES": occasional 1/2 pack/day 1 pack/day 1+ pack/day

Do you have a living will/advance directive? Yes No

Have you ever had a blood transfusion? Yes No

History reviewed. No changes Additions as noted above

Physician's signature: _____

Date: _____

Signature on File, Assignment of Benefits, Financial Agreement

Beneficiary Name (print)

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to East Ridge Eye Center for services furnished to me by East Ridge Eye Center. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. East Ridge Eye Center accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

2. MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to East Ridge Eye Center, if possible, or otherwise to me.

3. RELEASE OF INFORMATION: East Ridge Eye Center may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to East Ridge Eye Center for reimbursement for services rendered, and (2) any health care provider for continued patient care. East Ridge Eye Center may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. OTHER INSURANCE: I understand that East Ridge Eye Center maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office, and that East Ridge Eye Center has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by East Ridge Eye Center if I belong to a plan that does not appear on the above-mentioned list.

5. NON-COVERED SERVICES: I understand that East Ridge Eye Center contracts with health care service plans (i.e. HMOs, PPOs) state items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services which are determined by the health care service plans not to be covered. Examples of non-covered include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with East Ridge Eye Center to obtain necessary health care service plan authorizations.

6. I agree that in return for the services provided to the patient by East Ridge Eye Center, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to East Ridge Eye Center for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to East Ridge Eye Center. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to East Ridge Eye Center. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.* If you fail to notify us of any insurance changes and a claim is sent to the insurance company that you have previously reported to us, there will be a \$50.00 processing fee to re-file with another insurance company. This fee along with any outstanding balances is to be paid prior to re-filing with the corrected insurance company. I understand the importance of notifying East Ridge Eye Center of any insurance changes and agree to do so.

Beneficiary Signature or Authorized Party

Date