caris eye centers

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 ☐ Shortnes 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	☐ YES	☐ YES	Hypertension	☐ YES	☐ YES
Arthritis	☐ YES	☐ YES	Thyroid Disease	☐ YES	☐ YES
Asthma	☐ YES	☐ YES	Blindness	☐ YES	☐ YES
Cancer	☐ YES	☐ YES	Cataracts	☐ YES	☐ YES
COPD	☐ YES	☐ YES	Crossed Eyes	☐ YES	☐ YES
Depression	☐ YES	☐ YES	Glaucoma	☐ YES	☐ YES
Diabetes	☐ YES	☐ YES	Macular Degeneration	☐ YES	☐ YES
Elevated Cholesterol	☐ YES	☐ YES	Retinal Detachment	☐ YES	☐ YES
Irregular Heartbeat	☐ YES	☐ YES	Retinal Disease	☐ YES	☐ YES
Drug Allergies	☐ YES	☐ YES Please list Allergies:_____			

SURGICAL HISTORY

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

Eyelid Surgery	☐ YES	Eye Muscle Surgery	☐ YES
Cataract Surgery	☐ YES	LASIK or PRK	☐ YES
Corneal Surgery	☐ YES	Radial Keratometry (RK)	☐ YES
Other Eye Surgery	☐ 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**