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OPHTHALMOLOGY & WELLNESS

Patient Information

First name: _____ MI: _____ Last Name: _____

Date of Birth: ____/____/____

Address: _____ City: _____ State: _____ Zip Code: _____

Preferred Phone: □ Home □ Work □ Cell (_____) _____

Alternate Phone: □ Home □ Work □ Cell (_____) _____

Email: _____ SSN#: _____

Gender: □ Male □ Female

Marital Status □ Single □ Married □ Divorced □ Widow □ Separated

Employer_____ Occupation _____

Retired □ No □ Yes From_____

Birth Country: □ USA □ Other_____

Primary Language: □ English □ Other:_____

Race/Ethnicity: □ White □ Black □ Hispanic/Latino □ Asian □ Prefer not to specify □ Other ___

Emergency Contact _____ Phone # _____

Relationship: □ Spouse/Partner □ Child □ Parent □ Other _____

If patient is on Medicare, are you under care by a Skilled Nursing Facility (SNF)? □ Yes □ No

If patient is minor or dependent, Name of Responsible Party _____

Relationship to patient: _____Phone#: _____

Address: _____ City: _____ State: _____

Please provide signed Power of Attorney document, if applicable

Primary Care Physician: _____ Phone #:_____

Pharmacy Name: _____ Phone #:_____

Referral Doctor (OD/MD/DO): _____ Phone#: _____

When was your last eye exam?_____ By whom? _____

Please Read and Sign Below:

I authorize the physicians and staff of Envision Ophthalmology & Wellness to perform procedures necessary to assess and diagnose my condition properly and to perform treatments as may be prescribed by my physician during any and all visits to Envision Ophthalmology & Wellness. I understand that I am financially responsible for ALL charges for services rendered to me by the physicians and staff of Envision Ophthalmology & Wellness.

Patient name: _____ D.O.B: _____

Patient Signature: _____ Date: _____

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Insurance Information

If you are a **commercial patient or Medicare advantage** patient we are an out of network provider. As a courtesy we will provide you with a superbill for fee for service items, should you wish to submit a receipt for reimbursement with your insurance company. There is no guarantee that your insurance company will pay for all services rendered. Any medical services not covered by an individual's insurance plan are the patient's responsibility. **Payment is due in full to Envision Ophthalmology & Wellness at the time of your visit and two weeks prior to surgery.**

Original Medicare Patients (Part B) as a courtesy we will bill your insurance. Any medical services not covered by an individual's insurance plan are the patient's responsibility and payment in full is due at the time of visit. It is the patient's responsibility to pay any deductible or any portion of the charges as specified by the plan at the time of visit. **Co-pays are required at the time of services**. To help with correct co-pay and insurance billing it is important that you keep the office up to date with your insurance information.

Should collection proceedings or other legal action become necessary to collect an overdue account, I understand and agree that Envision Ophthalmology & Wellness has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. I agree to pay all collection fees in the amount up to forty percent (40%) of the total unpaid balance due, plus court costs and filing fees incurred by Envision Ophthalmology & Wellness. I understand and agree that should Envision Ophthalmology & Wellness be awarded judgment relating to this agreement or any debt incurred thereof, I will pay a service charge of one and one-half percent (1-1/2%) per month, eighteen percent (18%) per annum, beginning on the date of judgment.

It is the patient's responsibility to ensure that any required referrals for treatment are obtained before the visit or the patient may be financially responsible due to lack of the referral at time of service.

We are happy to help with insurance questions relating to how a claim was filed. However, specific coverage issues can only be addressed by the insurance company. The phone number for the insurance company's member services department can usually be found on your insurance card.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and good communication. Questions about financial arrangements may be directed to the physician's office at any time. Please do not hesitate to contact us. We are here to help you!

Health Insurance Coverage (To be completed by ALL patients)

Primary Insurance:_____ ID#: _____ Group#: _____

Policy Holder Name: _____

Relationship to Pt: □ Self, □ Spouse, □ Child Policy Holder Date of Birth: _____

Secondary Insurance: _____ ID#: _____ Group#: _____

Policy Holder Name: _____

Relationship to Pt: □ Self, □ Spouse, □ Child Policy Holder Date of Birth: _____

Patient name: _____ D.O.B: _____

Patient Signature: _____ Date: _____

Financial Policies

Recognizing the need for patients to understand what is expected regarding payment of medical services, we have established our financial policy. Some of these Items are required by law. It is our goal to remain sensitive to our patients' needs while providing quality medical care, and we encourage you to contact our office if a problem should arise regarding your account.

1. All co-pays and co-insurance required by your insurance company must be paid at the time services are rendered. We accept cash, check, and credit card. There is a $25.00 service charge on all returned checks. After receiving a returned check, Envision Ophthalmology & Wellness will only accept cash, money order, or credit card.
2. If you do not have insurance, payment in full is expected at the time of service unless financial arrangements have been made in advance with our billing department.
3. We are participating providers with Original Medicare. This means that we must accept Medicare's allowed charge for the services rendered. Medicare will pay 80% of the approved amount. The patient is responsible for the remaining 20%, plus any out-of-pocket deductible. We will write off the difference between what we charge and what Medicare approves. Please remember that although we accept assignment for Medicare, the patient is responsible, by law, for any portion of the approved amount not paid by Medicare or a secondary insurance company. **I understand I am responsible for any deductible, co-pay, co-insurance and/or any non-covered services.**
4. Responsibility for payment for services rendered to the child/children of divorced or separated parents rests with the parent who seeks treatment. Any court ordered judgment must be between the individuals involved, without including our facility.
5. In the unlikely event that your payment is returned to us unpaid, we will resubmit your payment, either electronically or by paper draft, to your financial institution up to two more times. We may also collect a return processing charge permitted by state law.
6. Under the program created by the Affordable Care Act (ACA), the federal government has mandated a 90-day grace period for all participants. What this means is that your doctors are notified when a patient is in their second or third month grace period and insurance premiums have not been paid current. How this impacts your medical claim is important as your insurance may or may not pay your claims. This signed notification represents your financial obligation that should your premiums fall behind, the charges during your grace period and any past due amounts will become your financial responsibility.
7. **MISSED APPOINTMENTS / SAME-DAY CANCELLATIONS –** If I miss an appointment or fail to give at least 24 hours' notice of cancellation, I may have a $100 "no show" fee or a $50 "rescheduling fee".
8. **RETURNED CHECKS –** I understand there is a $50 charge for any check that is returned for insufficient funds.

Patient Signature: _____ Date: _____

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Acknowledgement of Notice of Privacy Practices

Our *Notice of Privacy Practices* provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy.

By signing this form, you acknowledge that you have received a copy of our *Notice of Privacy Practices* and have had an opportunity to read it, I also understand that I may speak with the Privacy Officer if I have any questions.

Patient name: _____ D.O.B: _____

Patient Signature: _____ Date: _____

Authorization to Disclose Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We have explained that disclosures may be made to family and friends related to the patient's health. It has also been explained that we will only disclose information relevant to current treatment. I authorize the following persons to discuss my medical care and billing/insurance information with the Envision Ophthalmology & Wellness staff on my behalf:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

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Patient Health & Medical History Form

Patient name: _____ D.O.B: _____

Current Eye Medications: (please list below) ☐ None ☐ I have a medication list ☐ AREDS vitamins	Current Other Medications: (please list below) ☐ None ☐ I have a medication list
Allergies and Drug Reactions ☐ No known drug allergies Do you smoke? Yes/No Are you a former smoker? Yes/No Do you drink? Yes/No If yes, how often? Do you use street drugs? Yes/No Family Eye History: ☐ Macular Degeneration ☐ Diabetic Eye Disease ☐ Glaucoma ☐ Iritis/Uveitis ☐ Retinal Tear/Detachment ☐ Retinal Vein Occlusion ☐ Corneal Disease ☐ Keratoconus ☐ Cataracts ☐ Other:	Eye conditions and previous surgeries: ☐ Macular Degeneration ☐ Diabetic Eye Disease ☐ Glaucoma/Glaucoma suspect ☐ Iritis/Uveitis ☐ Retinal Tear/Detachment ☐ Retinal Vein Occlusion ☐ Corneal Disease ☐ Keratoconus ☐ Cataracts ☐ Wear Glasses? Daily/Reading/Driving ☐ Wear contact lenses/monovision? ☐ Other: ☐ List surgery type/dates/surgeon (including LASIK/PRK):

Medical Conditions:

Endocrine:

- ☐ Diabetes:
  - Type 1, since age ____
  - Type 2, since age ___
  - Last A1c
  - Pills
  - Insulin
- ☐ Thyroid Disease
- ☐ Liver Disease
- ☐ Pituitary Problem
- ☐ Other:

Cardiovascular:

- ☐ Hypertension
- ☐ High Cholesterol
- ☐ A-fib
- ☐ Arrythmias
- ☐ Carotid Artery Blockage
- ☐ Heart Attack, Date:
- ☐ Heart Disease
- ☐ Bleeding/clotting Disorder
- ☐ Other:

Neurologic:

- ☐ History of Stroke, Date:
- ☐ TIA, Date:
- ☐ Epilepsy
- ☐ Headaches/Migraines
- ☐ Ocular Migraines
- ☐ Multiple Sclerosis
- ☐ Brain tumor
- ☐ Dementia
- ☐ Parkinson's Disease
- ☐ Other:

Ear-Nose- Throat:

- ☐ Allergies-Seasonal
- ☐ Dizziness or Vertigo
- ☐ Hearing Impaired
- ☐ Other:

Lung:

- ☐ Asthma/COPD
- ☐ Arthritis
- ☐ Sleep Apnea
- ☐ Sarcoidosis
- ☐ Other:

Medical Conditions (continued):

Autoimmune-Skin-Muscular:

- ☐ Rosacea
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Connective Tissue Disorder
- ☐ Dermatitis/Eczema/Psoriasis
- ☐ Fibromyalgia
- ☐ HLA B-27
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Scleroderma
- ☐ Sjogrens
- ☐ Other:

Renal:

- ☐ Renal Failure
- ☐ Dialysis
- ☐ Other:

Digestive:

- ☐ Chron's Disease
- ☐ Irritable Bowel Disease
- ☐ Ulcerative colitis
- ☐ Other:

Psychiatric:

- ☐ Anxiety
- ☐ Bipolar
- ☐ Depression
- ☐ Developmental Delay
- ☐ Other:

Cancer: (specify type/treatment)

Pregnant or breastfeeding?

Infectious Disease:

- ☐ HIV/AIDs
- ☐ Cold Sores
- ☐ Hepatitis, Type:
- ☐ Sexually Transmitted Infections
- ☐ Tuberculosis
- ☐ Toxoplasmosis
- ☐ Histoplasmosis

Surgical History: (non eye surgeries)

Review of Systems:

- ☐ **Not experiencing any of the below symptoms**

General: □ Any weight change ? □ Fevers? □ Chills?

Head: □ Headaches? □ Dizziness? □ Injury?

Ears: □ Change in hearing? □ Ringing in ears?

Nose: □ Bleeding? □ Sinus congestion?

Mouth: □ Ulcers? □ Bleeding? □ Dentures?

Neck: □ Stiffness? □ Pain? □ Tenderness? □ Masses? □ Swelling? **Breast:** □ Cancer? □ Tenderness? □ Swelling?

Chest: □ Trouble breathing? □ Wheezing? □ Cough? □ Coughing blood? **Heart:** □ Chest pains? □ Palpitations?

Abdomen: □ Pain? □ Nausea? □ Vomiting? □ Diarrhea? Constipation? □ Liver problems?

Musculoskeletal: □ Pins/ needles feeling? □ Weak? Numb? □ Back pain? □ Joint pain?

GU: □ Trouble urinating? □ Blood in urine? **Skin:** □ Rash? □ Pigmentation changes?

Neurologic: □ Weakness? □ Tremor? □ Seizures? □ Changes in mentation?

Psychiatric: □ Depressive symptoms? □ Changes in sleep habits? □ Changes in thought content?

Other: