PATIENT FORM

GENERAL INFORMATION

First, Last, MI, Preferred Name

Street Address

City, State, Zip

Phone, Type

Phone 2, Type

Email

Preferred Contact Method *cell phone* | *email* | *text* | *other (please explain)*

Patient Social Security Number

Date of Birth

Male/Female

Occupation/Employer *full-time* | *part-time*

Marital Status *married* | *single* | *divorced* | *legally separated* | *widowed*

Language, Race, Ethnicity

Emergency Contact Person and Phone

INSURANCE INFORMATION

Vision Insurance

Vision Insurance Member Name

Vision Insurance Member ID#

Vision Insurance Member Date of Birth

Primary Medical Insurance

Primary Member Name

Insurance ID#

Insurance Policy#/Group ID#

Primary Member Date of Birth

Primary Member Social Security Number

Primary Member Employer

Your Relationship to Primary Member *spouse* | *child* | *other (please explain)*

Secondary Medical Insurance

Secondary Medical Insurance Member Name

Secondary Medical Insurance ID#

Secondary Medical Insurance Policy #/Group ID#

Secondary Medical Insurance Member Date of Birth

Secondary Medical Insurance Member Social Security Number

Your Relationship to Secondary Medical Insurance Member

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Patient name: ______________________________ Date: ______________________________

EYES: DO YOU (the PATIENT) HAVE ANY OF THESE PROBLEMS TODAY?

Macular Degeneration	Discharge	Iritis
Blurred Vision	Double Vision	Itching
Bothersome Night Glare	Dry Eye	Poor Night Vision
Burning	Eye Pain	Redness
Cataract	Eye Strain	Retinal Problems
Conjunctivitis	Floaters	Sensitivity to Light
Diabetes	Glaucoma	Tearing
Diabetic Retinopathy	Headache	Total Loss of Vision

OTHER ORGANS: DO YOU or HAVE YOU had ANY OF THESE CONDITIONS?

Constitution:

Developmental Disabilities

Cancer

Fatigue Syndrome

ENT:

Hearing Loss

Sinusitis

Dry Mouth

Laryngitis

Neuro:

Multiple Sclerosis

Epilepsy

Cerebral Palsy

Brain Tumor

Migraine

Migraine

Cardiovascular:

High Blood Pressure

Heart Attack

Stroke

Heart Disease

Vascular Disease

Respiratory:

Cigarette Smoker

Asthma

Bronchitis

Emphysema

COPD

Sleep Apnea

Allergies:Immune

Environmental Allergies

Rheumatoid Arthritis

Lupus

Sjogren's Syndrome

GU:

Kidney Disease

Prostate Cancer

Benign Prostate

Pregnant

Nursing

Herpes

Chlamydia

Other STDs

Musc/Skel:

Arthritis

Osteoarthritis

Fibromyalgia

Muscular Dystrophy

Ankylosing Spondylitis

Osteoporosis

Integ:

Eczema

Rosacea

Psoriasis

Cold Sores

Shingles

Endo:

Type 1 Diabetes

Type 2 Diabetes

Last A1C _____

Thyroid Dysfunction

Hormonal Dysfunction

Psych:

Depression

Attention Deficit

Anxiety Disorder

Bipolar

GI:

Crohn's

Colitis

Ulcer

Acid Reflux

Celiac Disease

Heme/Lymph:

Anemia

High Cholesterol

Bleeding Ulcer

....

HAVE YOU EVER BEEN TOLD YOU HAVE:

___Glaucoma/ Glaucoma suspect ___Cataracts ___Macular Degeneration ___Retinal Problems

___Any Eye or Lid Surgery ___Lazy Eye ___Diabetic Eye Problems ___Other ______________

DO YOU USE: ___Alcohol ___Tobacco LIST YOUR HOBBIES: ________________________

MEDICATIONS YOU TAKE (include Eye Drops): ____________________________________

MEDICATIONS YOU ARE ALLERGIC TO:____

THINGS THAT RUN IN THE FAMILY: (father, mother, brother, sister)

___Arthritis	f m b s	___Lazy Eye (Amblyopia)	f m b s
___Cancer	f m b s	___Cataract	f m b s
___Diabetes	f m b s	___Macular Degeneration	f m b s
___High Blood Pressure	f m b s	___Glaucoma	f m b s
___Heart Disease	f m b s	___Retinal Detachment	f m b s
___Thyroid Disease	f m b s	___Crossed Eye (Strabismus)	f m b s

WHO IS YOUR PRIMARY CARE PHYSICIAN? __________________________________

PAYMENT/ FINANCIAL POLICY/ INSURANCE (01.01.15)

INSURANCE
We only file claims if we are a participating provider on your plan. We only file to 2 of your insurance companies for each date you are seen. If we do not accept your insurance plan, payment in full is expected on the day services rendered. Because of certain insurance rules, some services you want or need may not be able to be done on the same date. Vision plans only cover healthy eyes with no pre-existing eye pathology; Patients with certain medical conditions are billed to major medical insurance according to insurance rules.

PROOF OF INSURANCE
You are responsible for giving correct, complete, and current vision-plan and medical-plan information to Island EyeCare on the day the services are rendered. You must have your most current card and a photo ID at the time of the visit or the visit will be self-pay. If your claim is rejected or denied because you have failed to provide complete & correct information, the balance becomes your immediate responsibility. If you have more than one plan, you must give us each plan's information so that we can file the claims according to the "Coordination of Benefits" rules and regulations.

CLAIMS SUBMISSION
Island EyeCare will allow each of your insurance company(s) 30 days (time allowed by the insurance commissioner in the state of Florida) to pay or deny your claim. When requested, you must agree to provide any necessary information to your insurance company in order to process the claim.

CO-PAYMENTS, DEDUCTIBLES, NON-COVERED SERVICES and REFERRALS
You are responsible for any co-payments and deductibles on the day services are rendered. If your insurance requires a referral or pre-authorization for any portion of the visit it is your responsibility to obtain such prior to the visit. Any services that are not covered by your insurance plan, including Medicare, will be your responsibility on the day services are rendered. (For example a $50 refraction, which is the examination of your eyes for glasses, is usually a non-covered service by medical insurance and Medicare.)

The monies collected today are only an estimate of your share. You may owe additional monies to Island EyeCare after the insurance company issues its Explanation of Benefits.

FULL PAYMENT is DUE in 60 DAYS
We send your claim in 1-3 days of service. We reserve the right to be paid in full by you 60 days from the date you receive goods or services—EVEN IF THERE IS AN INSURANCE DISPUTE, EVEN IF THE INSURANCE COMPANY HAS REQUESTED MORE INFORMATION, NO MATTER WHAT the circumstance. 60 days from the date of service the bill is YOUR responsibility.

DEBT COLLECTION POLICY
We send statements monthly. Your account will accrue a $10.00 per month late fee if you fail to pay your entire balance within 30 days from the FIRST statement date. If you need to arrange a payment plan for your balance, there will be 20% interest applied per month to the open balance.

Your account will be sent to a collection agency if you fail to pay the balance or make arrangements to pay within 90 days from the date of the first statement. Substantial fees (100% of your balance) will be added to your account on the day it is sent to the collection agency.

AUTHORIZATION
*I have read this Payment/Financial Policy in its entirety and agree to abide by every section in the policy for today's goods and services and for all FUTURE goods and services.
*I authorize the release of any medical information or other information necessary to process this claim.
*I authorize direct payment of benefits from the insurance company to Island EyeCare.
*I permit a copy of this authorization to be used in place of the original.

PRINTED NAME :

TODAY's DATE:

SIGNATURE and DATE ______________________________

HIPAA: Notice of Privacy Practices

ACKNOWLEDGEMENT of RECEIPT

I acknowledge that I have been offered or have received a copy of Island Eyecare's "Notice of Privacy Practices".

AUTHORIZATION to DISCUSS MEDICAL INFORMATION

I authorize Island Eyecare doctors and/or staff to release or discuss my private medical information to the following:

__ No One

__ Spouse (name and date of birth) ____________________

__ Other (name and relationship) ____________________

Patient Name Printed:

Signature: ____

Effective Date: