PATIENT INFORMATION

LAST NAME: _____ **FIRST NAME:** _____

ADDRESS: _____ **CITY:** _____

STATE: _____ **ZIP CODE:** _____ **HOME PHONE** _____

CELL PHONE _____ **WORK PHONE**_____

BIRTHDATE (MM/DD/YYYY) ___/___/___**SOCIAL SECURITY #** _____-_____-_____

MARITAL STATUS: _____**EMAIL ADDRESS** _____

Do we have permission to send you emails at this address? YES NO

OCCUPATION_____ **EMPLOYER**_____

MEDICAL INSURANCE _____**MEDICAL INSURANCE ID** _____

VISION INSURANCE _____**VISION INSURANCE ID**_____

POLICY HOLDER'S NAME_____ **DATE OF BIRTH**_____

RELATIONSHIP TO PATIENT_____

NAME OF PRIMARY CARE PHYSICIAN_____

ADDRESS _____**PHONE NUMBER**_____

How were you referred to our office?_____

Hobbies? (Example- Driving, computer, sewing, ect…) _____

Do you use a computer? ____How many hours a day?_____Are you a smoker? yes no used to

Does anyone in your immediate family have any of the following?

GLAUCOMA ____	**DIABETES** _____	**HIGH BLOOD PRESSURE** ____
ARTHRITIS ____	**CANCER** _____	**KIDNEY DISEASE** _____
THYROID _____	**MACULAR DEGENERATION**____	**RETINAL DISEASE**_____

What medications are you taking?_____

_____

Are you allergic to any medications?_____

Assignment and Release: HIPAA & Insurance & Debt Collection

I authorize payment of benefits directly to **Chelmsford Optometric Associates** for services rendered. I also authorize release of any medical information that may be required in determination of such benefits. I understand that some services may require approval by my primary care physician for coverage and that if I do not obtain that approval, I am financially liable for the services in their entirety.

I understand that my insurance carrier may not cover some services and products and that benefit information does not constitute approval of payment. Any amounts including but not limited to deductibles and fees not paid by my insurance carrier, will be my responsibility, and I hereby agree to promptly remit any such outstanding amounts to Chelmsford Optometric Associates. I acknowledge and agree that I am also responsible for any late or collection fees that may be applied if payment is not remitted promptly. I further acknowledge and agree that if I fail to remit payment promptly, Chelmsford Optometric Associates may exercise any and all rights and remedies available at law or in equity to collect such debt. Chelmsford Optometric Associates hereby affirms that it shall abide by the Fair Debt Collection Practices Act in the collection of any such debt from you.

I acknowledge that I have read and understood the above terms. I acknowledge that I received a copy of Chelmsford Optometric Associates' 'NOTICE OF PRIVACY, HIPAA' policy.

Signature_____Date_____

Dilation VRS. Optomap

Retinal exams are recommended annually. The purpose of these tests is to detect and monitor signs of Macular Degeneration, Glaucoma, Cataracts, as well as conditions such as Diabetes, High Blood Pressure, Cholesterol and Tumors. There are 2 types of tests that we provide to accomplish this. You DO NOT need to have both tests.

DILATIONS use drops to dilate or enlarge the pupil of the eyes to allow the doctor to get a better view of the inside of your eyes. These drops blur vision for a length of time, which varies from person to person, and may make bright lights bothersome. It is not possible to predict how much your vision will be affected. Because driving may be difficult immediately following your exam, it is best to make arrangements not to drive yourself. Adverse reactions, such as acute angle-closure glaucoma, may be triggered by the dilating drops. This is extremely rare and treatable with immediate medical attention. This test does require additional in office time and may need to be re-scheduled for another day.

An OPTOMAP provides us much the same information as a dilation without using any kind of drop. It takes less than 5 minutes and does not have any side effects on vision. It documents yours eyes present condition with a digital scan allowing us to follow changes over time and detect early changes, which may otherwise have gone unnoticed. This test can be done today. It is an enhancement to the general exam for a small fee of $20.

PLEASE CHECK ONE.
____ I would like to administer dilating eye drops at any of my visits as required by my eye condition.
____ I would like the OPTOMAP retinal exam done today for an additional cost of $20
____ I understand the risks and benefits of a retinal eye exam, and at this time I hereby decline both tests

_____ _____
Signature Date

Vision Plans VRS. Medical Insurance
Please read carefully

We often have patients that have both vision and medical insurance. They are very different in the terms of the services they cover and it's important to understand those differences. Vision coverage is mainly designed to determine a prescription for glasses, help pay for the eyeglasses or contact lenses, and to generally evaluate the health of the eyes. It is not designed to be used for medical conditions, diagnostic or screening tests and/or treatment plans.

When a medical diagnosis or condition is present (such as high blood pressure, diabetes etc.) or an eye disease (such as infections, dry eye, allergies, cataracts etc.), it is necessary to file the claim for your visit with your major medical carrier and the co-pays for that insurance will apply as well as any non-covered service. Vision insurance does not cover medical eye problems just as medical insurance does not cover routine vision problems. Our office does not make these rules; they are defined by the insurance carriers.

There is no way to know prior to the examination which type of insurance will apply or with whom our office will be able to file a claim for you. We make every effort to be a provider on every major carrier for your convenience and we will file those claims for you appropriately. In the event that we do not take your major medical/visions insurance, we will provide you with an itemized receipt so that you may file with your carrier for reimbursement.

I understand the paragraphs above and authorize Chelmsford Optometric Associates to file a claim with my insurance.

_____ _____
Signature Date

Contact Lens Evalulations

Contact lens wearers are at a greater risk for infection and corneal tissue damage. Due to this fact, a proper evaluation annually is critical. Evaluation fees are not covered by most insurance plans, as contacts are considered cosmetic and not necessary. However, some vision plans may provide coverage. The evaluation fee is determined by the complexity of the evaluation and your exact fee will be presented immediately following your evaluation. Evaluations fees are due the day the service is provided and start at $60. The evaluation period covers follow-up visits for 60 days from the time of the initial dispensing of lenses. There will be an additional $20 evaluating fee for any follow up visits related to the initial contact lens evaluation after 60 days and up to 90 days. After 90 days, from the initial contact lens evaluation, follow up ap

_____ _____
Signature Date