LIMERICK EYE associates pc

649 N. Lewis Rd., Suite 120
Limerick, PA 19468
Phone: 610-495-6851
www.limerickeyeassociates.com

Date:_____

Welcome to Our Office!!

□ Mr. □ Mrs. □ Dr. □ Miss □ Ms. □ Rev.

Patient's name_____

Preferred Name_____ Date of Birth_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____

Cell Phone _____

Preferred Way To Be Contacted (Please Mark) ☐ Cell ☐ Work ☐ Home

Email Address_____

Can we leave personal/medical information on a voicemail/answering machine or with a family member? ☐**Y** ☐ **N**

Are there any family members that you allow us to discuss your personal information with? Please list name (s).

_____

How did you hear about our office? (See below)

☐ Insurance ☐ Word of Mouth ☐ Internet ☐ Physician Referral ☐ Family Member(s) Come Here

☐ CareCredit ☐ Walking By

If you did an internet search, what words did you use? _____

If you were referred, whom may we thank? _____

Please list any other family members that come here_____

Occupation_____

Name of employer_____

(Please See Other Side)

Do you have any of the following: ☐ **Y** (**Please Circle Below**) ☐ **N**

Cataracts / Glaucoma/ Lazy Eye/ Macular degeneration / Diabetes/ High blood pressure/Allergies/Dry Eyes

Any immediate family members(parents, grandparents, siblings) have the following: ☐ **Y** (**Please Circle Below**) ☐ **N**

Glaucoma / Macular degeneration / Lazy Eye/ Diabetes

Any injuries or surgeries to your eyes? ☐ **Y** ☐ **N** Describe_____

Do you smoke? ☐ **Y** ☐ **N** Are you currently pregnant or nursing? ☐ **Y** ☐ **N**

List any <u>other</u> medical/eye health problems_____

Current List of Medications including drops (**Both prescribed and Over-the Counter**)

_____

_____

Family physician_____Date Last Seen_____

Previous eye doctor _____Date Last Seen_____

Allergies to any medications, drops or contact lens solutions? ☐**Y** ☐**N** (List)_____

Do you presently wear glasses? ☐**Y** ☐ **N** How old are the glasses?_____

Do you wear glasses for driving? ☐ **Y** ☐ **N**

Are you planning on purchasing new glasses today? ☐ **Y** ☐ **N** ☐ **Only if there is a change**

Do you presently wear contact lenses? ☐ **Y** ☐ **N** If no, have you ever worn contacts? ☐ **Y** ☐ **N**

As a contact lens wearer, do you have eyeglasses? ☐ **Y** ☐ **N**

Are you interested in wearing contact lenses? ☐ **Y** ☐ **N** Are you interested in LASIK? ☐ **Y** ☐ **N**

Do you have vision care insurance? ☐ **Y** ☐ **N** Name_____

Do you have medical insurance? ☐ **Y** ☐ **N** Name_____

Please note:

Insurance may cover none or only part of your fees. If we do not accept direct payment from your insurance plan, you will pay our office at the time of service and submit your receipt for reimbursement to your insurance company. If your insurance does not pay as expected, you are ultimately responsible for all charges. We cannot be responsible if you are not eligible for benefits. We will be happy to assist you with your claims. Please give any forms to the receptionist. If referred to a third-party collection agency, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

I acknowledge that I have been offered and read the *Notice of Privacy Practice* from Limerick Eye Associates, PC.

Signature:_____ Date:_____

Are you signing as a parent or legal guardian? ☐ **Y** ☐ **N** Please print name:_____

Insurance Policies

Limerick Eye Associates, PC participates with most major medical insurances and vision plans. We do our best to verify all copays, coinsurances and deductibles prior to your appointment. However, what we find out is not always a guarantee of payment until the explanation of benefits comes back from your insurance company. Some insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any balances not paid by your insurance company. All copays, coinsurances and deductibles will be collected at the time of the visit.

Optometry is in the unique position in that we participate with both medical and vision insurances. We will ask to make a copy of any insurance cards that you may have to keep on file.

Vision insurance is typically used for "wellness" visits and for materials such as eyeglasses and contact lenses. It does not cover any medical decision-making as it related to your ocular and systemic health.

Medical insurance is used for any visits that involve medical decision-making. Most visits will fall under this category.

- Many patients come in without any complaints, however sometimes it isn't until we do a thorough history and exam that we uncover some chief complaint that the patient forgot to mention or felt it wasn't important to bring up. This is the perfect example in which the patient was coming in "routinely" but really this visit would be billed medically.
- Prior patients that have any medical diagnosis on file will be billed medically such glaucoma, dry eyes, macular degeneration, cataracts etc.
- Patients that come in with a systemic condition that may have an effect on their ocular health such as diabetes will be billed medically.

Your medical insurance will also be billed for any procedures done in the office such as fundus photography, optical coherence tomography, automated visual field testing, visually evoked potential testing etc. There must be a medical diagnosis that supports the medical necessity of the procedure(s). Please ask the front desk for all codes that you may be coming back for so that you are prepared to call your insurance about coverage prior to your next visit.

Your signature below indicates understanding and agreement with our insurance policies as stated above and that you remain liable for payment of all service/procedures provided by Limerick Eye Associates, PC along with collection fees for any past due and unpaid amounts.

Patient Name _____

Signature_____Date: _____

Are you signing as a parent or legal guardian? ☐ Y ☐ N

Please print name:_____