INNOVATIVE EYECARE

NEW PATIENT INFORMATION FORM

Patient information - please print clearly Today's Date: _____

Full Name: _____ Male / Female

Address: _____ City, State, Zip: _____

Social Sec #: _____ Birthdate: _____ Age: _____

Hm phone: _____ Wk phone: _____ Cell: _____

Best way to contact you: Hm Wk Cell Eml Marital Status: Single Married Divorced Widowed Hobbies: _____

Occupation: _____ Email: _____

Emergency Contact: _____ Phone #: _____

Who may we thank for referring you to us? _____

May we add you to our office Facebook page? Y / N May we contact you via email? Y / N

Responsible Party (if different from above)

Name of person responsible for account if not the patient: _____

Address: _____ City, State, Zip: _____

Hm phone: _____ Wk phone: _____ Cell: _____

Employer: _____ Relationship to patient: _____

Insurance Information

Insurance: _____ Group #: _____

Subscriber: _____ ID #: _____

Patient's relationship to subscriber: Self Spouse Child Dependant

Subscriber's employer: _____ Subscribers date of birth: _____

Please read and sign below

We will be happy to bill your insurance for you as a *courtesy* provided that you bring your insurance card with you to your visit. You may also submit insurance claims yourself. We must also emphasize that as your eye care providers, our relationship is with you, not your insurance company, with whom we have no legal relationship. While the filing of insurance claims is a courtesy we extend to our patients, all charges (deductible amount, co-insurance, or any balance not paid by your insurance company) are your responsibility from the date the services are rendered. If we are not billing your insurance, you are financially responsible for all services from the date the services are rendered. Questions or concerns regarding charges, insurance coverage or benefits will be addressed with the office manager or any other staff members, not with the doctor.

I acknowledge that I have completed all of the information to the best of my knowledge. I authorize the eye doctor to release any information about my records to pertinent third party payers and/or other health practitioners if needed. **Lastly, I understand that returns and/or exchanges of any eyewear, as seen necessary by a staff member, will be done so by office credit and no refunds will be given. Any eyewear returns or exchanges may be subject to a restocking fee.**

X _____ Date: _____

NOTICE OF PRIVACY PRACTICES

Innovative Eyecare
l6870 Southcenter Parkway
Tukwila, WA 98188

This summary discloses how health information about you may be used. A full notice of your privacy rights may be requested for you to review.

Innovative Eyecare uses health information about you for treatment, to obtain payment for your treatment with your authorization as required, for administrative purposes, and to evaluate the quality of care that you receive.

Innovative Eyecare will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Innovative Eyecare may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Innovative Eyecare may disclose your information for public health activities and governmental function in order to comply with workers compensation laws and regulations. You have the right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

Innovative Eyecare must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of this notice, notify you if it is unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to disclose your health information for reasons other than those listed above and permitted under law.

_____ _____

Patient signature Date

_____

Print name

This form will be retained in your health record.

Innovative Eyecare
Patient Financial Responsibility Disclosure Statement

Medical Insurance

We have contracts with many insurance companies. We will bill them as a service for you. As the *Patient* or *Responsible Party*, you are responsible for any balance if your insurance company refuses to pay for any reason.

The person signing on behalf of the *Patient* as the *Responsible Party* must:

- Inform Innovative Eyecare of the current address and/or phone number for the
- *Patient* and *Responsible Party*.
- Present all current insurance cards (Vision and Medical) prior to each visit.
- Pay any required co-pay at the time of the visit.
- Pay any additional amount owing within 30 days of receiving a statement from
- our office.

Note: When our office receives an Explanation of Benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you.

Non-Payment on Account
Should *Collection* proceedings or other legal action become necessary to collect overdue amount, the patient's *Responsible Party* should understand that Innovative Eyecare has the right to disclose to an outside *Collection Agency* all relevant personal and account information necessary to collect payment for services rendered. The *Patient*, or patent's *Responsible Party* understands that they are responsible for all costs of collection. This will be added to the outstanding balance.

Please Note: A $32.50 FEE WILL BE CHARGED FOR ALL RETURNED CHECKS.

By signing below, you agree to accept full financial ***responsibility as a Patient*** who is receiving medical and/or vision services, or as the *Responsible Party* for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

_____
Patient Name (Please Print)

_____
Patient Signature / Date

_____
Responsible Party Name (Please Print)

_____
Responsible Party Signature / Date

Medical History Questionnaire

Vision History

Are you having difficulties with your vision? **YES** **NO** If YES, then what type? Distance Intermediate Near Other _____

Do you wear glasses? **YES** **NO** If yes, how old is your current pair of daily glasses? _____

How old are your prescription sunglasses?_____Your backup glasses?_____

Do you spend any time on the computer? **YES** **NO** How long per day? _____

Do you wear contact lenses? **YES** **NO** If yes, how old are you contacts? _____

Type of contact lenses you wear: **Gas Permeable** **Soft** **Extended Wear** **Disposable** **Overnight**

If you wear disposable lenses, how often do you replace them?_____

What solution do you use to clean your contact lenses with? _____

Please circle any of the following you have had:

Crossed Eyes Lazy Eye Droopy Eyelid Protruding Eye/s Glaucoma Retinal Disease
Cataracts Eye Infection Eye Injury Eye Surgery

Personal Medical History

List any medications that you take(including over the counter meds, oral contraceptives, aspirin and home remedies)

_____

Do you have any allergies to medications? NO YES If yes, please list medication

_____

Please list all major injuries, surgeries and/or hospitalizations you have had _____

_____

Females, are you pregnant or nursing? NO YES

Please note any general medical history for the following conditions

			If yes, please explain
Respiratory problems (shortness of breath, cough)	NO	YES	
Chronic fatigue, fever, unexpected weight gain/loss	NO	YES	
Ear, nose or throat problems	NO	YES	
Skin conditions (rashes, dryness)	NO	YES	
Musculoskeletal problems (arthritis, muscle pain)	NO	YES	
Heart problems (disease, blood pressure, irregular beat)	NO	YES	
Cancer	NO	YES	
Diabetes	NO	YES	
High Cholesterol	NO	YES	
Kidney Disease	NO	YES	
Liver Disease	NO	YES	
Thyroid Disease	NO	YES	
Neurologic problems (numbness, paralysis, headache)	NO	YES	
Psychiatric problems (depression, anxiety)	NO	YES	

Other _____

Family History

Are there any medical or eye diseases that run in the family (heart disease, diabetes, cancer, glaucoma, macular degeneration)?

YES **NO** If yes, please specify _____

_____