Mountain View Eyecare

Thomas G. Berbos, M.D.

NAME:____ Preferred Name____________________
Last First MI

DATE OF BIRTH:_____________________________ SOC. SEC. #: _______________________

HOME PHONE #:_______________________CELL #:_______________WORK #:_____________

EMAIL: ____

ADDRESS:____
City State Zip

PREFERRED METHOD OF CONTACT: (Circle One) Text Email Cell Home Work

MARITAL STATUS: M______ S______ D______ W______ GENDER: (Circle One) Male / Female

RACE (check all that apply): ☐American Indian or Alaska Native ☐Asian ☐Black or African American
☐Native Hawaiian or Other Pacific Islander ☐White

ETHNICITY : ☐Hispanic or Latino ☐Not Hispanic or Latino LANGUAGE:___________________

PATIENT (or parent's) EMPLOYER____

OCCUPATION:____

SPOUSE'S NAME:_________________WHO REFERRED YOU TO OUR OFFICE?_____________

PERSON TO NOTIFY IN CASE OF EMERGENCY:

NAME: __________________________ HOME #:________________ WORK #: _______________

RELATIONSHIP TO PATIENT:________________________

INSURANCE INFORMATION:

WE WILL BILL A MAXIMUM OF 2 MEDICAL OR 1 VISION INSURANCE PER DATE OF SERVICE.

PRIMARY MEDICAL INSURANCE COMPANY NAME : _______________________________

POLICY HOLDERS NAME:_______________________ __Group# __________ID#________________

POLICY HOLDERS SOC. SEC #:_________________ D.O.B:__________(if other than patient)

SECONDARY MEDICAL INSURANCE COMPANY NAME: _____________________________

POLICYHOLDER'S NAME:_________________________ Group #__________ID #_______________

POLICYHOLDER'S SOC. SEC #:_________________ D.O.B:____________(if other than patient)

VISION INSURANCE COMPANY NAME: ____

POLICYHOLDER'S NAME:_________________________ Group #__________ID #_______________

POLICYHOLDER'S SOC. SEC #:_________________ D.O.B:____________(if other than patient)

I UNDERSTAND THAT PAYMENT FOR ANY UNPAID BALANCES WILL BE MY RESPONSIBILITY. In the event that my bill goes unpaid, MVE may turn my account over to a collection agency. Any fees incurred by MVE to collect on my bill will be my responsibility.

____
Patient Signature Date

PARENT (Legal Guardian):____
Name Soc. Sec. # D.O.B

Signature on file, Assignment of Benefits, Financial Agreement

______________________________ ______________________ Disregard if you do not have Medicare

Beneficiary Name (print) **Medicare Number**

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Mountain View Eyecare, for services furnished me by Mountain View Eyecare. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Mountain View Eyecare accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Mountain View Eyecare, if possible or otherwise to me.

3. RELEASE OF INFORMATION: Mountain View Eyecare may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Mountain View Eyecare for reimbursement for services rendered, and (2) any health care provider for continued patient care. Mountain View Eyecare may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State of Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. OTHER INSURANCE: I understand that Mountain View Eyecare maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that Mountain View Eyecare has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Mountain View Eyecare if I belong to a plan that does not appear on the above mentioned list.

5. NON-COVERED SERVICES: I understand that Mountain View Eyecare's contracts with health care service plans (i.e., HMOs, PPOs) related only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnished to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Mountain View Eyecare to obtain necessary health care service plan authorizations.

6. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Mountain View Eyecare, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Mountain View Eyecare for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Mountain View Eyecare. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Mountain View Eyecare. ***However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.***

______________________________ ______________________

Beneficiary signature or Authorized Party **Date**

Sig on file 021506 le

MOUNTAIN VIEW EYECARE
MEDICAL AND SOCIAL HISTORY

PATIENT NAME: ______________________ **DATE:** ____________

Reason for visit: ______________________

Family Doctor: ______________________

Previous Opthalmologist: ______________________ Date of Last Exam: ____________

Optometrist: ______________________ Date of Last Exam: ____________

Drug Store: ______________________ Location: ____________

	PERSONAL MEDICAL HISTORY	FAMILY MEDICAL HISTORY			
		Mother	Father	Grandparent	Sibling
Diabetes	No Yes Year Type				
Thyroid	No Yes				
Heart/Cadiovascular	No Yes				
Hypertension	No Yes				
Arthritis/Bone Joint	No Yes				
Auto Immune	No Yes				
Cancer	No Yes				
Kidney	No Yes				
Ear/Nose/Throat	No Yes				
Gastrointestinal	No Yes				
Other	Explain:				

	PERSONAL OCULAR HISTORY	FAMILY OCULAR HISTORY			
		Mother	Father	Grandparent	Sibling
Cataracts/IOL					
Glaucoma					
Macular Degeneration					
Misalignment (Lazy Eye)					
Trauma					
Other					

ALLERGIES:

MEDICATIONS (Including Over the Counter)

Use back of form if you need more space

TOBACCO USE: None Pack/day 1 + Packs/day

ALCOHOL: None 2-3 X wee 2-7 X week More than 1 per day X 7 days

Signature: ______________________

301 Saddle Drive, STE B, Helena, MT 59601
Phone: 406-442-3937
Fax: 406-442-3366

Acct. #________

Patient Name: ____ Date: __________

Please state the purpose of your visit today. Why are you here?

____

Do you have: Diabetes Dry Eyes Cataracts Glaucoma

Many patients have a Routine Eye Exam benefit as part of their health insurance or with a separate vision plan. When you have medical coverage and routine coverage, which plan should be billed for your visit? Your insurance company says it depends on the reason you are here today.

Please indicate what type of exam you would like to receive today?

(Check one:) **Medical Exam** **Routine Vision Exam**

Medical Benefit: Your medical benefit is billed if you are here for medical care such as:

- Evaluation of an ocular disease: Glaucoma, Dry Eyes, Cataract or Retinal Disease
- Complaint such as pain, red eyes, tearing, burning, floater, flashes of light, etc..
- To follow an existing condition such as diabetes, autoimmune disease or use of a high risk medication such as plaquenil
- Ancillary testing such as a visual field, OCT or fundus photo's

Vision Benefit: Your vision benefit is billed if you are here for a routine exam such as:

- A "healthy" eye exam. You have no underlying health issues affecting the eye.
- You would like your eyeglass and/or contact lens prescription updated.

The above definitions are based on the guidelines of your insurance company and vision care plans and Mountain View Eyecare is contractually obligated to follow them.

I authorize Mountain View Eyecare to bill the following insurance or vision plan and have provided them with the necessary information. I understand I will not be able to change my mind once this claim has been processed because Mountain View Eyecare cannot resubmit a claim to a different carrier.

____ ____________________

Name of Plan (please print) Date

____ ____________________

Signature of Patient or Guardian Relationship to Patient