DR. MONICA L. CROSS

Fort Meade Family Eyecare

PATIENT INFORMATION

Primary reason for visit _____ Today's date: _____

Patient's name: - Mr. Mrs. Ms. Dr. _____ Male Female

Patient's date of birth: _____ Vision insurance & Member #: _____

Cell phone: _____ Medical insurance company: _____

Home phone: _____ Benefits # (TRICARE ONLY): _____

E-mail: _____ Policy Holder's name: _____

Address: _____ Policy Holder's date of birth: _____

City/state/zip_____ Policy Holder's last 4 SS: _____

REGARDING INSURANCE: If we are a contract provider for your vision insurance company, we will be happy to bill you insurance for you. If not, it is customary in the vision care profession that the patient is responsible for the entire fee at the time of the exam and the insurance company reimburses the patient. You should attach a copy of your fee slip to your insurance form and send it to your insurance company for reimbursment. If you have any questions, we will be happy to help you. Payment is due upon time of service.

SPECTACLE/CONTACT LENS INFORMATION

Do you wear glasses? ☐ yes ☐ no

Do you wear contacts? ☐ yes ☐ no

What type of contact lenses ☐ soft ☐ hard (RPG) Brand: _____

Previous contact RX: _____ OD (right eye) _____ OS (left eye)

Base curve: _____ Diameter: _____

How often do you put in a fresh pair of contacts?: _____

PERSONAL HEALTH INFORMATION

Last eye exam: _____ Dilated? ☐ yes ☐ no Eye doctor: _____

Are you pregnant or nursing? ☐ yes ☐ no

Surgery

Eye surgery: _____ Other surgeries: _____

Medications

(including vitamins, asprin, oral contraceptives, over the counter, or eye drops): _____

_____

_____

Allergies (medicine, food, or enviromental): _____

_____

Do you drink alcohol? ☐ yes ☐ no If yes, ☐ mild ☐ moderate ☐ severe

Do you use tobacco products? ☐ yes ☐ no How often do you drink? _____

Do you use illegal drugs? ☐ yes ☐ no How often do you smoke? _____

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PERSONAL HEALTH INFORMATION CONTINUED

Flashes of light/Floaters	☐yes ☐no ☐unsure	Psoriasis	☐yes ☐no ☐unsure
Double vision *(2 of everything)*	☐yes ☐no ☐unsure	Skin cancer	☐yes ☐no ☐unsure
Dry eyes	☐yes ☐no ☐unsure	Sinus congestion/disease	☐yes ☐no ☐unsure
Burning	☐yes ☐no ☐unsure	Dry mouth/Throat	☐yes ☐no ☐unsure
Itchy eyes	☐yes ☐no ☐unsure	Cronic cough	☐yes ☐no ☐unsure
Fuzzy vision *(not clear)*	☐yes ☐no ☐unsure	Blood disorder	☐yes ☐no ☐unsure
Heart disease	☐yes ☐no ☐unsure	Anemia	☐yes ☐no ☐unsure
High Cholesterol	☐yes ☐no ☐unsure	Vascular problems	☐yes ☐no ☐unsure
High blood pressure	☐yes ☐no ☐unsure	Ankylosing spondylitis	☐yes ☐no ☐unsure
Diabetes *(type___)*	☐yes ☐no ☐unsure	Arthritis	☐yes ☐no ☐unsure
Gout	☐yes ☐no ☐unsure	Downs syndrome	☐yes ☐no ☐unsure
Crohn's disease	☐yes ☐no ☐unsure	Muscular dystrophy	☐yes ☐no ☐unsure
Thyroid problems	☐yes ☐no ☐unsure	Myasthenia gravis	☐yes ☐no ☐unsure
Renal/Kidney problems	☐yes ☐no ☐unsure	Headaches/migraines	☐yes ☐no ☐unsure
Pituitary problems	☐yes ☐no ☐unsure	Seizures	☐yes ☐no ☐unsure
IBD/IBS	☐yes ☐no ☐unsure	Psychiatric	☐yes ☐no ☐unsure
Gastrointestinal disorder	☐yes ☐no ☐unsure	Alzheimer's	☐yes ☐no ☐unsure
AIDS/HIV	☐yes ☐no ☐unsure	Anxiety disorder	☐yes ☐no ☐unsure
Herpes simplex/Zoster	☐yes ☐no ☐unsure	Autism	☐yes ☐no ☐unsure
Lyme disease	☐yes ☐no ☐unsure	Brain Trauma	☐yes ☐no ☐unsure
Tuberculosis *(TB)*	☐yes ☐no ☐unsure	Depression	☐yes ☐no ☐unsure
Sarcoldosis	☐yes ☐no ☐unsure	Asthma	☐yes ☐no ☐unsure
Ocular rosacea	☐yes ☐no ☐unsure	ADHD	☐yes ☐no ☐unsure
		Dyslexia	☐yes ☐no ☐unsure

FAMILY HISTORY

Please notate any family history of the following including parents, grandparents, siblings, children, living and/or deceased in the following:

EYE DISEASE/CONDITION	yes	no	unsure	Relationship to you:
Blindness	☐	☐	☐	_____
Cataracts	☐	☐	☐	_____
Crossed eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular degeneration	☐	☐	☐	_____
Retinal detachment/disease	☐	☐	☐	_____

SYSTEMIC DISEASE/CONDITION	yes	no	unsure	Relationship to you:
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart disease	☐	☐	☐	_____
High blood pressure	☐	☐	☐	_____
Kidney disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid disease	☐	☐	☐	_____

Other: _____

PATIENT'S SIGNATURE: _____ Today's date: _____

(If patient is under 18 years old, parent signature is required.)

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ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE AND DISCLOSURE AUTHORIZATION

Patient Name:_____ **DOB:**_____

By signing this form, you acknowledge that Dr. Monica Cross has provided you with access to a copy of her Health Insurance Portability and Accountability Act (HIPAA) Privacy Notice, which explains how your health information will be handled in various situations. By law, we are required to have you sign this form annually or when any of the contact information that you wish for us to communicate with regarding your health information has changed.

The practice has provided me access to HIPAA Privacy Notice. I understand I may request a copy for my personal use.

I acknowledge that I have read, understand and agree to the above.

Patient's Signature:_____**Today's date:**_____
(If patient is under 18 years old, parent signature is required.)

RESPONSIBILITY STATEMENT

Your insurance is a method for you to receive reimbursement for fees you have paid to the optometrist for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them not with our office. It is your responsibility to pay in advancefor the deductible, coinsurance, or any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible in advance for your bill.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be as valid as the original.

FINANCIAL RESPONSIBILITY / MEDICAL RELEASE

By signing this statement you agree to be financially responsible for all charges and to have your information shared for insurance benefit varification.

Patient's Signature:_____**Today's date:**_____
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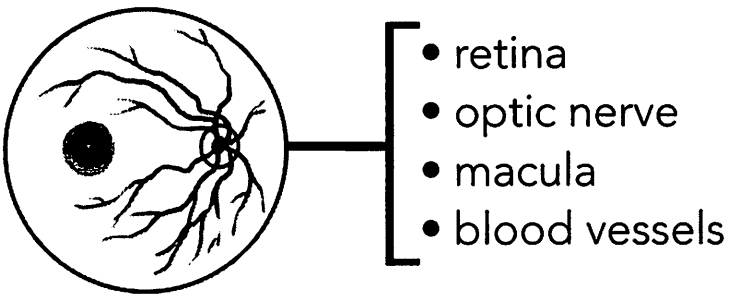
CONSENT FOR RETINAL PHOTOGRAPHY

WHAT IT HELPS US DOCUMENT

RETINA



When indicated the doctor will need to examine the internal structures of the eye in greater detail for signs of disease. Indicators might include *diabetes, high blood pressure, complaints of flashes, floaters, side vision loss, high prescription, one seeing eye, history of trauma, or you are not correcting to 20/20 during the exam.* Examination of the internal structures in greater detail is done using pupillary dilation or retinal photography.

Retinal photography takes a quick picture of the internal structures of the eyes. Dilation drops are usually not needed. With retinal pictures the patient leaves seeing exactly as they did when they walked into the office. In addition the pictures are permanent part of your record from which to refer to in order to monitor the health of your eyes in subsequent years. The images will be shared with you during your visit. The cost is ***$39*** dollars if your insurance does not cover it.

Patients reserve the right to refuse any test or diagnostic procedure recommended. If a patient refuses they assume all the risk for potentially not detecting any serious eye condition.

Do you want this procedure? Circle one.

RETINAL PHOTO ***ACCEPT*** ***DECLINE***

Patient's Signature:_____**Today's date:**_____

(If patient is under 18 years old, parent signature is required.)

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PATIENT FINANCIAL AND PRACTICE POLICIES

The patient must provide current, accurate billing/patient information. Inaccurate information will result in all charges for services becoming the sole responsibility of the patient/responsible party. Patients must notify the practice of any changes in information (adress, insurance, and phone numbers) and provide insurance cards at each visit for verification.

Copayments are to be paid at the time services are rendered.

No refunds of professional services will be given.

Self-pay patients: We welcome patients with or without health or vision insurance. All services must be paid in full at time of service.

It is the responsibility of the patient to pay any outstanding bills promptly. Once an account becomes delinquent, it will go to our collection agency.

Dr. Cross is happy to preform a contact lens fit for Kimbrough Eye Clinic patients for contact lenses with an eye glass prescription from Kimbrough that has been done within the last 30 days.

Additional fees (These may not apply to you!):

- *Completion of an MVA vision certificate is $20*
- *Accompanying visual field test for MVA vision certificate is $20*
- *Completion of any form pertaining to school, employment, etc is $15*
- *We charge a fee for copying* ***medical records****. The state of Maryland allows a fee for copying records not to exceed .76 cents for each page, plus the actual cost of postage, handling, and preparation fee of $23, if the records are sent to another provider. A medical release form must be completed and signed by the patient before any records will be copied, faxed, or released.*

By signing I understand the above policies.

Patient's Signature:_____ **Today's date:**_____

(If patient is under 18 years old, parent signature is required.)

By signing here I understand the and accept the no show/late cancel policy shown to me .

Patient's Signature:_____ ***Today's date:***_____

(If patient is under 18 years old, parent signature is required.)