VISION FOR YOUR FUTURE

PUTNAM PARKWAY EYECARE

FINANCIAL POLICY

Our goal at Putnam Parkway Eyecare is to provide high quality, personal medical eye care, products, and services. Your understanding of our financial policy is an essential part of your eye care and treatment. If you have any questions regarding this policy, please feel free to discuss them with our staff.

Full payment for professional services is due at time of service for all co-pays and deductibles not covered by insurance. Acceptable forms of payment include cash, personal check, and credit cards. For your convenience, we accept Visa, MasterCard, and Discover. If eye wear or contacts are ordered, a minimum 50% deposit is required, and the balance is due upon delivery. A $30 fee will be charged for returned checks.

Your insurance contract is an agreement between you and your insurance carrier. As a courtesy, we make every effort to get benefit details and authorization prior to your appointment and will file your insurance today (up to 3 plans) on your behalf. For patients carrying health and/or vision insurance, we need the policy holder's social security number and date of birth.

We require having a copy of your medical insurance card. To be fair to our highly trained medical eye care provider, medical insurance may be billed for this visit or for additional testing. This may occur depending on the reason for the visit, referral/correspondence with another medical provider, and/or a medical prescription involved in your care.

After 90 days from the date of your eye examination, any outstanding balances will be sent to our collection agency if it is deemed that the account has been in default of payment. If we turn your account over to a collection agent, you will be responsible for any administrative fees, attorney fees, and court costs. If you have any questions about your bill, please contact our office as soon as you receive it.

I have read and understand the financial policy of this practice and I agree to be bound by its terms. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize my insurance company to pay to the doctor all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

Signature: _____

Date: _____

Teresa M. Rohrs, O.D.
Darcie L. Jerwers, O.D.
Putnam Parkway Eyecare
102 Putnam Parkway Suite B
Ottawa, OH 45875
Phone: (419) 523-3937

Acknowledgement Of Privacy Practices

Date

I, _____ acknowledge that I have received a copy of the Notice of Privacy Practices from Putnam Parkway Eyecare.

I have listed individuals that are authorized to receive my protected health information. I am aware that I can revoke the authorization for any individual at any time, but must do so in writing.

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Representative & Relationship Date
(Required if patient is a minor or an adult unable to sign form)

The following individuals have my authorization to access my Protected Health Information

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMERGENCY CONTACT NAME/NUMBER

GENERAL INFORMATION

Last, First, MI (Preferred Name)
Street Address
City, State, Zip Code
Home Phone Cell Phone
E-Mail Address
Patient Social Security Number
Date of Birth Male/Female
Occupation Employer
Marital Status (Circle) Married Single Divorced Legally Separated Widowed
Language, Race, Ethnicity

INSURANCE INFORMATION

Vision Insurance
Vision Insurance Member Name
Vision Insurance Member ID#
Vision Insurance Member Date of Birth

Primary Medical Insurance
Primary Member Name
Insurance ID#
Insurance Policy#/Group ID#
Primary Member Date of Birth
Primary Member Social Security Number
Primary Member Employer
Your Relationship to Primary Member (Circle) Spouse Child Other (Explain)_____

Secondary Medical Insurance
Secondary Medical Insurance Member Name Date of Birth
Secondary Medical Insurance ID#
Secondary Medical Insurance Policy#/Group ID#
Secondary Medical Insurance Member Social Security Number
Your Relationship to Secondary Medical Insurance Member

Date of Last Eye Exam
Currently Wear Glasses?
Currently Wear Contacts?
Reason For Today's Visit
Primary Care Physician
How Did You Hear About Us?_____

Have you experienced, or been treated for any of the following? Circle all that apply.
Allergic Eye Disease Cataracts Crossed Eye Dry Eye Glaucoma LASIK or RK Lazy Eye Macular Degeneration Retinal Detachment

Has any family member been treated for any of the following: Circle all that apply.
Cataracts Crossed Eye Glaucoma LASIK or RK Lazy Eye Macular Degeneration Retinal Detachment

Are you currently experiencing, or have experienced, any of the following: Circle all that apply.
Blurry Vision (Near or Distance) Burning Discharge Double Vision Dryness Excess Tearing/Watering Eye Infection Eye Pain or Soreness Floaters or Spots Halos Headaches Itching Light Flashes Light Sensitivity Redness Sandy or Gritty Feeling

Have you experienced, or been treated for any of the following? Circle all that apply.
AIDS/HV Allergies Arthritis Asthma Blood/Lymph Disorder Cancer Diabetes Ears, Nose, Throat Conditions Gastrointestinal Conditions Heart Disease High Blood Pressure High Cholesterol Kidney Disease Lupus Neurological Conditions Psychiatric Disorder Seizures Skin Conditions Stroke Thyroid Dysfunction

Has any family member been treated for any of the following: Circle all that apply.
AIDS/HV Allergies Arthritis Asthma Blood/Lymph Disorder Cancer Diabetes Ears, Nose, Throat Conditions Gastrointestinal Conditions Heart Disease High Blood Pressure High Cholesterol Kidney Disease Lupus Neurological Conditions Psychiatric Disorder Seizures Skin Conditions Stroke Thyroid Dysfunction

Current Medications (prescription and over-the-counter and dosage)

Medication Drug Allergies

Height
Weight
Are you pregnant or nursing?
Do you smoke?
Have you ever smoked?

Patient Name:

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STANDING CONSENT TO ACCESS EXTERNAL PRESCRIPTION HISTORY

Date

PLEASE SIGN ONLY AFTER YOU HAVE READ AND UNDERSTAND ALL OF THE FOLLOWING:

I, _____ , whose signature appears below, authorize Putnam Parkway Eyecare and its Affiliated Providers to view the external prescription history via the RxHub service for the patient listed below.

Please initial below. By initialing, you are agreeing to the respective terms and conditions set below and are fully agreeing to the terms above.

_____ I understand that prescription history from multiple other unaffilitated medical providers, insurance companies and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions issued back in time for several years.

_____
Patient Name

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT I AUTHORIZE THE ACCESS TO MY PRESCRIPTION HISTORY.

_____
Signature of Patient or Guardian Date If Guardian, Relationship to Patient

Witness to Patient/Guardian's Signature Date

Prefered Local Pharmacy

Mail Order Pharmacy