Today's Date: ____________

Welcome To Our Office

New Patients: Please complete the entire form front and back.

Patient Information

Last Name: ____
First Name:____________________________ **MI:**_______
Nickname:____
Date of Birth:__________________________ **Age:**_______
Sex: ☐ M ☐ F **Race:** ☐W ☐B ☐H ☐A ☐Other
Marital Status: ☐Minor ☐Single ☐Partnership ☐Engaged ☐Married ☐Divorced ☐Widowed
Address:____
____
City:_______________________ **State:**______**Zip:**_______
Home Phone:_______________________________________
Work Phone:_______________________________________
Cell Phone:____
Social Security: ___________ - ___________ - ___________
Employer (Or School):_______________________________
Occupation (Or Grade):______________________________
Spouse (Or Parent):_________________________________
Email Address:
____

Communication Preference: ☐Text Message ☐Email ☐Phone

What is the major purpose of this visit?
____

Any problems with your current contact lenses or glasses?
____

How did you hear about us?
____

Who may we thank for referring you to our office?
Name of friend or relative:
____

Patient Eye History

Date of Last Eye Exam:_____________________________

By Whom?____

Have you ever tried contact lenses? ☐Yes ☐No

Do you currently wear contact lenses? ☐Yes ☐No

What Kind?____

Solutions Used?_____________________________________

Insurance Information

How will you settle your account today?
☐ Cash ☐ Credit Card (Visa, MasterCard o Discover)

Routine Vision Plan:__________________________________
Subscriber's Name:_____________________________________
Subscriber's SSN:______________________________________
Subscriber's Birth Date:_________________________________

Primary Medical Insurance:____________________________
Subscriber's Name:_____________________________________
Subscriber's SSN:______________________________________
Subscriber's Birth Date:_________________________________

Secondary Medical Insurance:__________________________
Subscriber's Name:_____________________________________
Subscriber's SSN:______________________________________
Subscriber's Birth Date:_________________________________

Responsible Party

Person responsible for payment on this account:
☐Self ☐ Other, Name:___________________________
Relationship:____
SSN:____
Cell #:_________________ Home Phone #:_______________
Email:____
Address:____
City:__________________ State:________ Zip:_____________
Name of Employer:______________________________________
Work Phone:____

Lifestyle Questions

Do you… (check box if your answer is YES):
☐ ...work at a computer?
☐ …interested in a "test drive" of the latest contact lens designs?
☐ …spend time outdoors? How much? ___________ Hrs./Week
☐ …have prescription sun wear?
☐ …play any sports? If yes do you have sports specific eye wear? ☐Yes ☐No
☐ …want information on Laser Vision Correction Surgery?

Have you ever experienced, been diagnosed or treated for any of the following?
☐ Double Vision ☐ Tired When Reading ☐ Spots/Floaters
☐Tearing ☐Dryness/Gritty Eyes ☐ Glare/Halos
☐Macular Degeneration ☐Retinal Detachment
☐Blindness ☐Eye Lid Problems

Patient Medical History

Name of Family Physician:______________________________
Address:____
Phone Number:______________________________________

Have you ever had any operations, severe illnesses, injuries, eye infections, or eye surgery? ☐Y ☐N If yes, list:
____
____

Allergies: ☐ Y ☐ N if yes, list:
____

If female, are you currently Pregnant? ☐ Y ☐ N If yes, how many weeks?______________________________

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of **ALL** medications including, vitamins, & birth control pills)
____
____
____
____
____
____
____
____
____
____
____

Eye Drops:____
____

Social History

1. **Do you use tobacco products?** ☐ Y ☐ N
If yes, what type/ how much/ how long?
____

2. **Do you drink alcohol?** ☐ Y ☐ N
If yes, what type/ how much/ how long
____

3. **Do you use illegal drugs?** ☐ Y ☐ N
If yes, what type/ how much/ how long?
____

4. **Have you ever been exposed to or infected with:**
☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ None

Family Medical/Eye History (Check All That Apply)

Is there a family medical history of any of the following:
☐No ☐Yes
**Please List Relationship. Indicate Mother's or Father's Side:
Blindness ☐______________________________
Cataracts ☐______________________________
Corneal Problems ☐______________________________
Dry Eye ☐______________________________
Glaucoma ☐______________________________
Lazy Eye ☐______________________________
Macular Degeneration ☐______________________________
Retinal Problems ☐______________________________
Diabetes ☐______________________________
Heart Disease ☐______________________________
High Blood Pressure ☐______________________________
Thyroid ☐______________________________
Sickle Cell Disease/Trait ☐______________________________
Other ☐______________________________

Review of Systems **Please Check and Circle All that Apply

Review of Systems:	Self (Yes)	Self (No)
Constitutional Symptoms (e.g., fever, weight loss, cold)		
Ears, Nose, Mouth, Throat (Chronic)		
Cardiovascular (cholesterol, heart, hypertension, TIA)		
Respiratory (asthma, bronchitis, COPD, emphysema)		
Gastrointestinal (acid reflux, Crohn's, peptic ulcers)		
Genitourinary (prostate, UTI, Incontinence, STD)		
Musculoskeletal (arthritis, Myasthenia gravis)		
Integumentary (eczema, psoriasis, rosacea, skin cancer)		
Neurological (headaches, migraines, seizures)		
Psychiatric (ADD/ADHD, anxiety, bipolar, depression)		
Endocrine (diabetes, hyperthyroid, hypothyroid)		
Hematologic/Lymphatic (anemia, sickle cell)		
Allergic/Immunologic (Lupus, Sarcoidosis)		
Others not listed		

Dilation: Please Check One ☐**Consent** for dilation ☐**Decline** my dilation
☐**Reschedule** (additional fees apply)

Financial Policy and Patient Agreement

The following is the financial policy and office disclosure policy of Dr. Alice C. Sun & Associates, P.C. Please read and sign prior to treatment.

Payment is due at the time of service, unless prior arrangement have been made. This includes copays, co-insurance, deductibles, and any non-covered services. Delinquent payments will be billed to you and is considered past due if not received within 30 days of service. Any past balances will need to be paid before new services are rendered. **Please Initial By ALL That Apply To You.**

______**SELF-PAY:** If you are a self-pay patient or you are under-insured we can offer you our lowest allowable discounted rate for services. We accept CASH, VISA, MASTERCARD and DISCOVER only. We do not accept checks. If you realize you have insurance after you have paid for services rendered, we will provide you with an itemized receipt to submit to your insurance company. By initialing you are requesting this prompt pay discount and agree to the terms.

______**VISION PLANS:** These are annual wellness benefits or discount plans that provide specific benefits and discounts for routine exams only. You acknowledge that you have reviewed and understand the differences between routine and medical exams. If we are in network with your routine plan we will file your claim. You agree to pay for any non-covered services.

______**MEDICAL PLANS/MEDICARE:** Medicare does not cover routine eye exams, which is an exam related to the prescribing of eyeglasses or contact lenses and without ANY medical complaints. However, Medicare does cover medical related eye exams but deductible, copay and co-insurance applies. We will file your claim using medical codes and fees as determined by Medicare Allowables. ALSO, Medicare will not cover a refraction which is the process of determining the eyes best corrected vision for eyeglasses and contact lenses. Other medical insurance plans model Medicare and follow similar guidelines. You agree to pay your refraction fee at time of service as well as any contact lens fitting fees if applicable. You agree to present your active insurance cards, any necessary paperwork (i.e. referrals, medications list, documents requiring signatures), and proof of ID at each visit, otherwise you may be required to pay at the point of service.

______**NON-COVERED SERVICES:** Certain services are not covered by your insurance. Many insurance plans do not cover contact lens fittings, which range from $55 to $90 in addition to the vision/medical exam. You agree to make payment for these series at time of rendering.

PLEASE READ AND INITIAL BY THE REMAINING NOTICES BELOW:

______**NOTICE OF PRIVACY PRACTICES:** We are HIPAA compliant and will adhere to Client Confidentiality as outlined in the Notice of Privacy Practices. You acknowledge that you have been provided with a copy of our office privacy policy. You may also request to have a copy. In order to better communicate with you and to service your account you acknowledge and agree that Dr. Alice C. Sun & Associates, P.C. and contracted partners* may contact you by home phone, cell phone (or any phone associated with your account), email, text, or postcard. We may leave a message on your answering machine, voicemail or with persons that may answer your phone, and we may release information/prescriptions to family members unless you notify us otherwise in writing. Methods of contact can include pre-recorded/artificial voice messages and/or use of an automatic dialing device. *Sourcenet Medical Billing is our contracted billing specialist.

______**PATIENT RESPONSIBILITY:** Having insurance is not a substitute for payment. We will try to obtain the most accurate information from your insurance company but they will issue a disclaimer that any quote of eligibility and benefits is not a guarantee of payment. You are ultimately responsible for knowing your coverage, including eligibility, in network providers, benefits, deductible, and copay information. By signing below you agree to be responsible for any unpaid portion regardless of denial reason. Any unpaid balances after 90 days will be sent to collections (*Receivables Management Corporation) and reported to all credit bureaus. The patient or responsible party is responsible for any collection fees charged to our office, including any finance charges, attorney fees, court costs, or any other administrative expenses.

_____**AUTHORIZATION TO REALEASE MEDICAL INFORMATION:** By signing below you authorize any holder of medical information about you to be released to the Health Care Financial Administration and its agents and any information needed to determine benefits or the benefits payable for related services. You assign payment to Dr. Alice C. Sun & Associates, P.C., and this assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be as valid as the original.

_____**DILATION:** Many eye diseases can be diagnosed early through dilation. We strive to dilate everyone if possible. Dilation is recommended if any of the following are true: you have never been dilated before, it has been two or more years since your last dilation, you have a strong prescription for glasses/contacts, you are over the age of 40, you or members of your family have eye diseases such as cataracts or glaucoma, or any health problems such as diabetes, high blood pressure, or cancer. You may experience difficulty with near reading and have sensitivity to lights for 3-6 hours afterwards. It is not advisable to operate heavy machinery. Most patients can drive after this procedure, but it is not advisable to do so until you feel comfortable with your vision. It may be helpful to have a driver with you.

_____**APPOINTMENT POLICY:** We have implemented a communication and reminder system. When an appointment is scheduled it is reserved especially for the patient. We urge patients to respond to our appointment reminders (text, email, phone) so that we may continue to reserve the appointment for you; failure to confirm appointments cause an interruption in the scheduling process, which creates inefficiency in the office. It can also result in the loss of your appointment spot. If you are unable to keep the appointment, you agree to notify our office 24 hours in advance. If you are going to be more than 15-20 minutes late for your appointment we recommend a call to update us on your arrival time; however, we may need to reschedule your appointment. Patients who do not adhere to the appointment policy or continuously miss appointments will lose optimum appointment times or lose office privileges for non-compliance.

I certify that I have read and understand the above information and agree to the terms.

*X*____

Patient or Guardian Signature Date