

The Eye Clinic, Inc
Patient Financial Policy

Thank you for choosing The Eye Clinic, Inc. We are committed to providing the finest quality eye care and treatment for our patients. Please understand that payment of your bill is considered part of your treatment. The Eye Clinic requires all patients to read and sign this Patient Financial Policy prior to seeing our doctors.

General Information:

When you come into The Eye Clinic for your appointment, you will be asked to provide us with a photo ID and your insurance card. You will be asked to verify your address, telephone number and insurance information. We will make a copy of your insurance card for our records. Also, please bring a listing of all the medications which you are currently taking.

Insurance:

Our physicians are contracted with most major insurance carriers, however, it is your responsibility to know whether or not they are on your insurance plan. For your convenience, we will bill both your primary and secondary insurance carriers on your behalf. Please be aware that all charges for services rendered at The Eye Clinic, Inc., are your responsibility whether your insurance pays or not.

Co-payments and Deductibles

If you have a Co-payment with your insurance carrier, you are required to pay it each time you come in for an office visit. If you have a deductible, you are required to pay for your visits in **full** until your deductible has been met. For your convenience, we accept cash, checks, Debit card, Visa, MasterCard and Discover.

Worker's Compensation/Motor Vehicle Accidents:

In order for us to file a claim with Worker's Compensation, you must fill out all required paperwork which is available in our reception area. We must have adequate information to bill either your MCO or Self-Insured plan. If you do not have this information available when you come in for your appointment, you will be responsible for all charges incurred until we receive this information from you.

If you are involved in a motor vehicle accident, and you come to our office for treatment, you will be responsible for payment of all charges incurred. We will provide you with a statement which you can turn into your medical or automobile insurance carrier for reimbursement of these charges.

No Insurance:

If you do not have medical insurance coverage, you must pay your bill in full at the time of service, unless you have made prior arrangements with our billing office.

Minor Patients:

The parent or guardian accompanying the minor patient(s) are responsible to pay all charges incurred for their appointment. For unaccompanied minor patients, the necessary co-payments, deductibles or outstanding balances are due and must be paid at the time of service.

Divorce:

Charges incurred by minors are the responsibility of the parent in which the child resides.

I have read this patient financial policy and I understand and agree to the terms and conditions of this policy.

Signature of Patient or Responsible Party

Date

Medical History Questionnaire

Name _____ Birth Date _____

Name of physician referring you _____ Physician Phone _____

Physician Address _____ Date of last eye exam _____

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas? If "yes," provide information.

	YES	NO	EXPLANATION OF PROBLEM
Constitutional Symptoms			
Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes			
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Distorted vision (halos)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mucous discharge	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sandy or gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foreign body sensation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excess tearing/watering	<input type="checkbox"/>	<input type="checkbox"/>	_____
Occasional tearing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glare/Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye pain or soreness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Infection of eye or lid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sties, Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fluctuating visual acuity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tired eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears, nose, mouth, throat			
Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Runny nose	<input type="checkbox"/>	<input type="checkbox"/>	_____
Post-nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry throat/mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____

	YES	NO	EXPLANATION OF PROBLEM
Respiratory (lungs/breathing)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular (heart/blood vessels)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal (stomach/intestines)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary (genitals/kidney/bladder)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Integumentary (skin and/or breast)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hematologic/Lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic/Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head allergy symptoms	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay fever symptoms	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____

PAST HISTORY

List any medications you take _____

List all major illnesses and injuries _____

List any surgeries you have had _____

Have you had crossed eyes, lazy eye, drooping eyelid, prominent eyes? _____

Do you have allergies to any medications ? YES NO

If YES, list medications _____

FAMILY HISTORY

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attacks	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sjogrens Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

OVER

SOCIAL HISTORY

Current occupation _____

Do you drive? YES NO

Do you have visual difficulty when driving? YES NO

Do you have problems with night vision? YES NO

Have you ever tried to wear contacts? YES NO

Do you currently wear glasses? YES NO

If YES, how long have you had the current pair? _____

Do you drink alcohol? YES NO

If YES, how many glasses a day? _____

Do you smoke? YES NO

If YES, how many packs a day? _____

Have you ever had a blood transfusion? YES NO

Have you ever been in intimate contact with a person who had a sexually transmitted disease? YES NO

History reviewed. No changes Additions as noted above

Physician's signature: _____ Date: _____

THE EYE CLINIC, INC. - PATIENT REGISTRATION

PLEASE PRINT

Today's Date _____

Patient Name		Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Referring Doctor		Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D	
Patient SSN		Phone	Age
Patient's Address			
Patient's Employer			Phone
Patient's Employer's Address			
Family Physician			
Spouse or Nearest Relative		Relationship	Phone
Address			
Employer & Address			
Bill To:			
Responsible Person's Name			SSN
Address			Phone
Employer			Employer Phone
Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			Insured Birthdate
Primary Insurance			Policy No.
Secondary Insurance			Policy No.
Workers Comp. No.	Employer at Time of Injury		Date of Injury

PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND CLAIM PAYMENT AUTHORIZATION

I HEREBY AUTHORIZE THE PHYSICIAN TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING THIS TREATMENT / ILLNESS / ACCIDENT, AND I HEREBY IRREVOCABLY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED. I AUTHORIZE AND DIRECT MY INSURER TO ISSUE PAYMENT CHECK(S) FOR BENEFITS DUE ME FOR THE SERVICES RENDERED BY MY PHYSICIANS OFFICE TO BE MADE DIRECTLY TO THEM. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.

I ALSO HEREBY AUTHORIZE AND GIVE PERMISSION TO MY ATTENDING PHYSICIAN, AND OTHER HEALTH PROFESSIONALS ASSOCIATED WITH MY PHYSICIAN, TO DISCUSS MY MEDICAL OR OTHER RELEVANT INFORMATION WITH MY PHYSICIAN'S LEGAL COUNSEL, ACCOUNTANT, MEDICAL MALPRACTICE CARRIER, AND BILLING AND CODING AGENTS, AS MAY BE DEEMED NECESSARY BY MY PHYSICIAN. A COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.

Patient (Parent or Guardian if Minor)

Date

Responsible Person or Insured

Date

STATEMENT TO PERMIT PAYMENT OF MEDICAL BENEFITS TO PROVIDER, PHYSICIAN, AND PATIENT

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE MY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I REQUEST THE PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE FOR PHYSICIAN SERVICES TO THE PHYSICIAN OR ORGANIZATION FURNISHING THE SERVICE OR AUTHORIZE SUCH PHYSICIAN OR ORGANIZATION TO SUBMIT A CLAIM TO MEDICARE FOR PAYMENT TO ME. I REQUEST THAT PAYMENT UNDER THE MEDICAL INSURANCE PROGRAM BE MADE EITHER TO ME OR TO THE ABOVE-NAMED PHYSICIAN'S OFFICE.

Patient (Parent or Guardian if Minor)

Date