WASHINGTON EYE CARE

MEDICAL HISTORY FORM

Name: _____ Date: _____

Who is your primary care physician (PCP)? _____ Does your visit today require a referral from your PCP? □ Yes □ No

FAMILY MEDICAL HISTORY: (Check all that apply)

□ Diabetes □ Cancer □ Macular degeneration

□ High Cholesterol □ Cataract(s) □ Retinal tear or detachment

□ High Blood Pressure □ Glaucoma □ Other: _____

PERSONAL OCULAR HISTORY: (Check all that apply)

□ Prescription glasses wearer: Current prescription is _____ years old. □ Contact Lens Wearer: hard / soft *(circle)*

□ Cataracts □ Amblyopia □ Diabetic retinopathy

□ Glaucoma □ Macular degeneration □ Retinal tear or detachment

□ Eye injury □ Corneal disorder □ Eyelid disorder

□ Eye misalignment (e.g., strabismus, lazy eye)

□ Previous eye surgeries (e.g., LASIK, PRK, cataract, etc.): _____

□ Previous eyelid surgeries: _____

PERSONAL MEDICAL HISTORY: (Check all that apply)

***Influenza Immunization received in the last 12 months** □ Yes □ No

***Pneumococcal Vaccine received in the last 5 years** □ Yes □ No

□ Diabetes (Year diagnosed: _____ , blood sugar range: _____ , last Hba1C if known: _____)

□ High Cholesterol □ High Blood Pressure □ Coronary artery disease □ Other heart problems: _____

□ Stroke or TIA □ Asthma □ COPD / emphysema □ Arthritis

□ Thyroid Disease □ HIV / AIDS □ Hay fever / allergies □ Autoimmune disease

□ Sinus Disease □ Eczema / dry skin □ Cancer (please specify): _____

□ Other medical history: _____

□ **Previous surgeries (and year of each):** _____

SOCIAL HISTORY:

Smoking/Tobacco: □ Never smoker □ Former smoker □ Current packs per day: _____

Use of Alcohol: □ None □ Occasional/Social □ 1-2 Drinks/day □ 3+ Drinks/day

LIFESTYLE:

Do you have difficulty getting around? □ Yes □ No

Do you have a risk of falling? □ Yes □ No

Do you have difficulty looking after yourself? □ Yes □ No

Do you live alone? □ Yes □ No

Do you drive? □ Yes □ No

Are you a computer user? □ Yes □ No

What type of work do you do? _____

MEDICATIONS (attach a separate sheet if necessary):

_____

_____

_____

ALLERGIES:

_____

_____

_____

Doctor's initials: _____

WASHINGTON EYE CARE

MEDICAL VS. ROUTINE EYE EXAM

I FULLY UNDERSTAND AND AGREE TO THE FOLLOWING:

Medical Eye Examination:

If I have an eye condition such as but not limited to cataracts, macular degeneration, glaucoma, dry eyes, or cornea problems, this examination will be billed to my **medical insurance**. It will be billed as a specialist visit; therefore, any specialist copays or coinsurance will apply and are due at the time of service.

Routine Vision Examination:

A visit only qualifies as a routine eye exam if I have no known or suspected eye problems and if I am only intending to receive a baseline eye evaluation and an updated glasses prescription. In some cases, if a medical diagnosis is made or if further treatment is required, my visit may not be eligible for a routine exam.

Washington Eye Care is currently **not** contracted with any vision insurance plans. However, if my vision insurance plan provides out-of-network coverage for a routine eye examination, I have the option of paying Washington Eye Care directly at the time of service, and then submitting a claim form and receipt to my vision insurance for reimbursement.

Alternatively, if my **medical insurance plan** covers a free routine eye examination once a year, Washington Eye Care can provide me with a routine eye examination and bill it directly to my medical insurance. Prior to my visit, I am responsible for knowing whether my medical insurance plan covers a free routine eye exam, as well as if the routine benefit has been used for the year. I understand that if my visit was billed as routine and rejected by my insurance, I will be responsible for the entirety of the bill.

Vision insurance plans that Washington Eye Care IS NOT contracted with include but are not limited to:

- VSP
- EyeMed
- Davis Vision

☐ My visit today is a routine eye exam. My medical insurance covers a routine eye exam, and the benefit has not been used for the year.

☐ My visit today is a routine eye exam. I plan to pay out-of-pocket, and then submit a claim form and receipt to my vision insurance for reimbursement.

☐ My visit today is a medical eye exam.

_____ _____

Signature of patient or guardian *Date*

_____

Printed name

WASHINGTON EYE CARE

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION FOR TREATMENT

I FULLY UNDERSTAND AND AGREE TO THE FOLLOWING:

I understand that as part of my healthcare, Washington Eye Care originates and maintains paper records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as: a basis for planning my care and treatment; means of communication among the many healthcare professionals who contribute to my care; a source of information for applying my diagnosis and surgical information to my bill; a tool for third party payors to verify services; and, a tool for continuous quality improvement and the overall continuum of my medical care. This release includes but is not limited to the release of information to other physicians' offices, medical facilities, insurance/managed care companies, and the Health Care Financing Administration (for Medicare recipients). I have been provided with the **Notice of Privacy Policy**, which provides a more complete description of information uses and disclosure. I understand my rights to: review the Notice prior to signing this consent; to object to the use of my health information for directory purposes; and, request restrictions prior to signing this consent; to object to the use of my health information for directory purposes; and, request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations. I understand that Washington Eye Care is not required to agree to restrictions I may apply and that I may revoke this consent in writing except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign or revoke this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I further understand that Washington Eye Care reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations.

I understand that Washington Eye Care may disclose my name, address, and phone number; the name of my scheduled treating physician; and time and place of my scheduled appointment(s), for the limited purpose of contacting me to notify me of a pending appointment or other healthcare related communication. I understand that Washington Eye Care may disclose to third parties (persons in my home) who answer my phone limited protected health information regarding pending appointments, and/or leave a reminder message on my voicemail system or answering machine.

_____ _____

Signature of patient or guardian *Date*

_____

Please Print Name

I authorize Washington Eye Care to release protected health information, including authorization to discuss account balances and details with the following persons:

Name of Person	Relationship	Date Authorized	Patient Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

WASHINGTON EYE CARE

FINANCIAL AGREEMENT

I FULLY UNDERSTAND AND AGREE TO THE FOLLOWING:

Billing of insurance companies is a service that Washington Eye Care provides to me for my benefit. Possession of a valid insurance card is not a guarantee of payment. Ultimately, the charge for their services is my responsibility. Washington Eye Care will make every effort, on my behalf, to collect payment from my insurance company first. I am responsible for any co-payment and co-insurance at the time of service.

- **Medicare Patients:** Washington Eye Care's physicians are Medicare participating providers. This means that Washington Eye Care will bill Medicare for the allowed fees. Medicare pays 80% of the allowed fee and the other 20% is either my responsibility or the responsibility of my Medicare Supplement insurance. I am also responsible for the annual Medicare deductible and all ***non-covered services**. The law requires that I be billed for any applicable deductible and the 20% patient responsibility portion.

- **Private Insurance:** If I have insurance coverage with a private carrier, Washington Eye Care will make every effort to bill my insurance company first. It is my responsibility to provide Washington Eye Care with accurate and current insurance information. If Washington Eye Care is unable to collect payment from my insurance carrier due to incorrect information or rejections, I will be responsible for the entire bill. I am also responsible for all ***non-covered services**. I may, of course, elect to pay on the day of my visit and then petition my insurance company for reimbursement.

Non-Covered Services**: There are some services that my medical insurance may not cover at all, and payment for these services is my responsibility. The most common non-covered service in ophthalmology is a ***refraction, which measures my eyes to see if new glasses or contacts will improve my vision. Payment for this service is either collected at the time of my visit or included in the statement for my visit.

Fee for Service: All payments that are my responsibility are due at the time services are rendered. Washington Eye Care is currently not accepting payment plans.

Medical Records: I understand that my medical records are the legal property of Washington Eye Care and I authorize the release of any medical records needed to ensure payment and coverage for the services that I receive.

Payment: Washington Eye Care accepts cash, VISA, Mastercard, American Express, Discover, or a personal check. There will be a $25.00 service charge for all returned checks.

_____ *(initial)* I accept financial responsibility for co-payments, deductibles, non-covered services, and claims denied by my insurance company.

_____ *(initial)* It is my responsibility to know whether my insurance company requires a referral from my primary care physician for my eye visits to be covered. If a referral is in fact required, it is my responsibility to secure and maintain these referrals from my primary care physician. If Washington Eye Care is unable to collect payment from my insurance carrier due to a lack of referral, I will be responsible for the entire bill.

_____ *(initial)* I request payment of authorized benefits by my insurance plan to be paid directly to Washington Eye Care, on my behalf, for services furnished to me by Washington Eye Care. I also request that Washington Eye Care submit claims for payment for those services on my behalf to my insurance carrier(s). If my insurance does not pay, I understand that I am responsible for payment in full.

_____ _____

Signature of patient or guardian *Date*

_____

Please Print Name