Focus On Eyes, P.C.

(TURN OVER)

Sue A Feather, O.D.

Patient Demographics/Financial Responsibility Form

Name:_____ Date of Birth:_____ Age _____ M/F

Address:_____ City:_____ Zip:_____

Home phone: (____)_____Cell Phone:_(____)_____Alt. Phone:_(____)_____

E-Mail:_____ **How did you hear about us?** **Family Referral Newspaper Online Other**

Health Insurance (Medical):_____Member ID:_____

Subscribers First and Last Name:_____

Group#:_____ Subscribers Date of Birth:_____ Relation:_____

Subscribers Address:_____City/Zip:_____

Vision Insurance:_____ Member ID#:_____

Group#:_____ Subscribers Name and Date Of Birth:_____

I give Focus On Eyes, P.C. permission to speak with the following people in regards to my health exam and insurance.

1._____

2._____

3._____

HIPAA PRIVACY ACT

I authorize the release of any medical information acquired in the course of my exam or treatment to process medical claims to further treatment to a referred doctor. I also acknowledge that I have received a copy of Dr. Sue Feather & Focus On Eyes notice of privacy practices. I am providing this in compliance with HIPAA regulations.

_____

Signature (Guardian signature if patient is a minor) Date

FINANCIAL RESPONSIBILITY

I certify that the information given by me in applying for the above listed insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Sue A. Feather, OD or to Focus on Eyes on my behalf for any services and materials furnished. I authorize any holder of medical information about me, be released to the Health Care Financing Administration, its agents and/or other Health Care Operations. For the purpose of, but not limited to, claim payments, provider review functions, and quality assessment. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above. I also understand that I may revoke this consent by written request, at any time, with this doctor. If revoked, all parties understand that all information-released prior to being notified of such revocation was made with my consent. I understand that I have the right to restrict the disclosure of specific information in my medical records if I request such restriction in writing. I also understand that my request for restriction may be denied if the information restriction is required above mentioned purposes.

However, even with prior authorization, we are not guaranteed payment by your benefit plan at any time. In the event that the Plan Sponsor determines that you are not eligible at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you do hereby agree to be financially responsible for any and all of the charges incurred by you and not paid by the Plan Sponsor.

In the event that you fail to make payment in full (in a timely manner) or if you fail to make a reasonable payment arrangement and your account becomes 60 days past due, you shall be liable for, and you agree to pay, all collection agency fees (not to exceed 33.3%), reasonable attorney's fees and court costs. By signing this statement you do hereby agree to be financially responsible for any and all charges incurred by you and not paid in a reasonable and timely manner. Any returned checks are subject to a $25 service charge.

Responsible Party (lifetime patient or guardian if patient is minor) Date

(Note: All deductibles and/or co-pays are due at time of service. We accept Cash, Debit, MasterCard, Visa, Care Credit, and Discover)

(TURN OVER)

Reason for visit:_____ **Would you prefer to be dilated? yes / no / if needed**

Primary Care Physician:_____ **Last Exam:**_____

Previous Eye Doctor:_____ **Last Exam:**_____

Do you now, or have you recently experienced any of the following:

□ Double Vision □ Blurred Vision □ Vision Loss □ Red, Painful Eyes

□ Foreign Body Sensation □ Headaches/Migraines □ Floaters □ Flashes of Light

Please check all medical conditions that apply:

□ Diabetes □ High Blood Pressure □ High Cholesterol □Thyroid Disorder

□ Seizures □Cardiovascular Disease □ Cancer □ Other:_____

Please check all ocular conditions that apply:

□ Cataracts □ Glaucoma □ Macular Degeneration □ Blindness □Crossed Eyes □ Lazy Eye

□ Retinal Disease □Chronic Eye Infections □Eye Injury _____

List any major surgeries in the past 24 months:_____

List any surgery/procedures on eyes:_____

List any medications (including oral contraceptives, aspirin, and over the counter meds):_____

_____

_____

List all medication allergies:_____

Any other major allergies (I.E. nuts, shellfish, tape, latex etc...)_____

List any medications/drops for your eyes (including over the counter):_____

Please check any of the following that apply to your immediate family history (parents, grandparents, aunts, uncles, and siblings):□ Blindness _____ □ Cataracts _____ □Crossed Eyes _____

□ Glaucoma _____ □ Macular Degeneration _____ □ Lupus_____

□ Retinal Detachment/Disease _____ □ Arthritis _____ □ Heart Disease_____

□ Cancer _____ □ Diabetes _____ □ Kidney Disease_____

□ High Blood Pressure _____ □ Thyroid Disorder _____

Tobacco use? □Yes □No □Previously **If yes**: packs per day?_____ How long?_____

Any alcohol use? □ No □Social □ 1-2 drinks per day □ More than 1-2 drinks per day **Do you use illegal drugs**? □ Yes □ No

Do you currently wear Glasses? □ Yes □ No **Purpose**: □ Distance □ Near □ Both(Lined bifocal/Trifocal or No line)

How often do you wear them? □Full time □ As needed □ Not often □ Never (□ Lost □ Broken)

How old are your glasses?_____ **Do you have problems with glare or driving at night**? □ Yes □ No

Do you wear contacts? □ Yes □ No Type: □ Hard RGP □ Soft Disposable (□ 1 wk □ 2 wk □ 1 month)

Brand:_____ How often do you throw them away?:_____ Solution:_____

Please list anything else you would like to discuss with the Doctor (I.E. trouble reading phone/newspaper/small print, trouble seeing computer screen, tired eyes, dry eyes etc.....) _____

_____