EYE
PHYSICIANS & SURGEONS

Patient Information

DATE_____

Name_____DOB_____Sex___
Phone Home_____Work_____Cell_____
SSN_____ Email Address_____
Address_____City/State_____Zip Code_____
Do you live in a skilled nursing facility? Y N Employer_____
Marital Status_____Guardian/Parent (Name/Number)_____
Primary Care Provider_____Referring Provider_____
Emergency Contact (Name/Phone Number)_____
Primary Insurance Company_____
ID#_____Group#_____Subscriber Name/DOB_____
Secondary Insurance Company_____
ID#_____Group#_____Subscriber Name/DOB_____

Patient Health History

Please list your current medications:_____
_____
_____
Do you have any allergies to any medications? Y N
If yes, please list the medication(s) and type of reaction(s)_____
Do you have an allergy to latex? Y N
Do you have an allergy to adhesive or tape? Y N
Do you wear glasses? Y N
Do you use tobacco? Y N Current Past Never
Please list any recent surgeries or hospitalizations including dates and reasons:_____
_____

Please indicate if you have the following:

Glaucoma Y N	Eye Injury/Surgery Y N	Amblyopia Y N	Cataract Y N
Macular Degeneration Y N	Strabismus Y N	Dry Eye Y N	Hypertension Y N
Stroke Y N	High Cholesterol Y N	Anxiety/Depression Y N	Cancer and type Y N
Heart Disease Y N	Thyroid Disease Y N	Arthritis and type Y N	Diabetes Y N
Allergies Y N	Flu Shot/Year Y N	Pneumonia Shot/Year Y N	Other:

Please indicate if you have a family history of the following:

Diabetes Y N	Glaucoma Y N	Mac Degeneration Y N	Heart Disease Y N
Amblyopia Y N	Cancer Y N	High Cholesterol Y N	Thyroid Disease Y N
Strabismus Y N	Hypertension Y N	Other:	

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FINANCIAL POLICY & CONSENT

Thank you for choosing Eye Physicians & Surgeons as your health care provider. We are committed to building a successful relationship with you and your family. Your clear understanding of our Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. You are asked to sign this acknowledgment stating you have read and agree to our Financial Policy prior to services being rendered.

We participate with most medical plans as well as EyeMed for a vision plan. It is important to understand that insurance is an agreement between you and your insurer. It is your responsibility to be aware of the limitations of your plan and what you may be responsible for financially. If we participate with your insurance, all services will be submitted to your carrier for you. We may collect co-payments, deductibles, and coinsurance for all covered services and your complete payment for non-covered and self-pay services at the time of service. We do not submit claims for those services your insurer has deemed non-covered or you deem "self-pay". Be advised that routine visits and refraction services are often non-covered. If your insurance plan requires a referral from your primary care physician, it is your responsibility to obtain the referral prior to your appointment. It is your responsibility to ensure that the doctor you are scheduled with participates in your plan and that the visit or procedure is a benefit of your plan. If we do not participate with your insurance, you have a deductible plan or the service is non-covered, payment is expected at the time of service.

What is the difference between Vision Insurance and Medical Insurance?

It is important that you understand that only Drs. Bowen and Fishilevich are the only providers that participate with EyeMed and **COVERS ROUTINE** well-eye exams only, which includes the refraction to determine your eyeglass prescription. Your plan may also provide discounts or allowances toward eyeglass frames, lenses, or contact lenses. As part of a routine well-care exam, the doctor examines your eyes for routine eye health and to determine the need for glasses or other refractive correction. If your routine well-eye examination reveals a medical condition or disease which requires special testing or follow-up care, the testing and subsequent examinations will be billed to your medical insurance as these are **NOT COVERED** by your Vision Plan. It is important to know that if you have a specific eye or vision complaint which is related to a new or pre-existing condition, such as cataract, glaucoma, diabetes, dry eyes, etc. or if you are here for a follow up appointment for a pre-existing condition as requested by a doctor, then your visit is **NOT COVERED** by your Vision Plan and will be billed to your medical insurance.

Please note that once your exam has been filed with your insurance provider we legally **CANNOT CHANGE** your examination documents or diagnosis codes.

At times it can seem like a complicated process and encourage you to contact your health insurance carrier with any questions that you may have about your coverage.

By signing this statement, I agree to be financially responsible for all charges. I understand that my insurance is not a substitute for payment, and it is my responsibility to pay, in advance, the deductible, the co-pay and any other balance not covered by my insurance company. I also understand that verification of my benefits is not a guarantee of payment. I understand that my signature requests that payment be made and authorize the release of my medical information necessary to pay the claim. In addition, I understand that I will be charged a $50.00 fee for any no-show appointments that I incur, and I will be charged 12% of my total visit bill after two statements for non-payment of monies that were directly my responsibility.

*Signature of Patient and/or Guardian*_____*Date*_____

Please visit our website to make payments, submit inquiries, and request appointments eyedocsct.com