Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_

Middle

First Name

Last Name

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please specify ethnicity:
 \_\_\_Hispanic or Latino
 \_\_\_Not Hispanic or Latino

Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: Married: \_\_\_ Widowed: \_\_\_ Single: \_\_\_ Divorced: \_\_\_

Please specify race:
 \_\_\_American Indian/Alaska Native \_\_\_ White
 \_\_\_ Native Hawaiian / Other Pacific Islander \_\_\_ Not Disclosed
 \_\_\_Black/African American \_\_\_ Asian

**Would you like to receive electronic reminders from our office? Please Circle: Yes No**

Employer’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **EMERGENCY CONTACT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Primary Care Doctor (First and Last Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Practice Name: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT / GUARDIAN / SPOUSE INFORMATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Name of Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I.D. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Insured’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY INSURANCE**

**SECONDARY INSURANCE**

Name of Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I.D. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT’S MEDICAL HISTORY QUESTIONNAIRE – Page 1**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Eye Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Previous Eye Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIC REACTIONS TO MEDICATIONS OR OTHER SUBSTANCES: \_\_\_\_\_ Y \_\_\_\_\_ N**

If yes, please list medication and reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of **Preferred Pharmacy**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently wear glasses? \_\_\_\_\_ YES \_\_\_\_\_ NO

Do you currently wear contact lenses? \_\_\_\_\_ YES \_\_\_\_\_ NO

How old are your current glasses? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY**

Do you engage in regular exercise? \_\_\_\_\_ YES \_\_\_\_\_ NO

Do you drink alcohol? \_\_\_\_\_ YES \_\_\_\_\_ NO If yes, how much: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? \_\_\_\_\_ YES \_\_\_\_\_ NO If yes, how much: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use recreational drugs? \_\_\_\_\_\_Yes \_\_\_\_\_ No If yes, how often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever smoked? \_\_\_\_\_ YES \_\_\_\_\_ NO When did you stop smoking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any Special Requirements: (Wheelchair, Interpreter, Walker, Service Animal): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have problems with any of these symptoms?**  **If yes, please check box.**

\_\_\_ Headaches / When did this start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Glare/Light Sensitivity / When did this start? \_\_\_\_\_\_\_\_

\_\_\_ Tired Eyes / When did this start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Amblyopia (Lazy Eye) / When did this start? \_\_\_\_\_\_\_\_\_

\_\_\_ Double Vision / When did this start? \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Sandy/Gritty Feeling / When did this start? \_\_\_\_\_\_\_\_\_

\_\_\_ Burning / When did this start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Drooping Eyelid / When did this start? \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Redness / When did this start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Infection of Eye/Lid / When did this start? \_\_\_\_\_\_\_\_\_\_

\_\_\_ Itching / When did this start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Crossed Eyes / When did this start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Loss of Vision / When did this start? \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Mucous Discharge / When did this start? \_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Floaters or Spots / When did this start? \_\_\_\_\_\_\_\_\_\_ \_\_\_ Fluctuation Vision / When did this start? \_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Dryness / When did this start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Distorted Vision (Halos) When did this start? \_\_\_\_\_\_\_\_

\_\_\_ Blurred Vision at Distance / When did this start? \_\_\_\_\_­­\_\_\_\_ \_\_\_ Eye Pain or Soreness / When did this start? \_\_\_\_\_\_\_\_\_

\_\_\_ Blurred Vision at Near / When did this start? \_\_\_\_\_\_\_\_\_\_\_\_ **\_\_\_** Loss of Side Vision / When did this start? \_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Excess Tearing/Watering / When did this start? \_\_\_\_\_\_\_\_\_\_

**PATIENT’S MEDICAL HISTORY QUESTIONNAIRE – Page 2**

**Do you have problems with any of these symptoms? If yes, please check box.**

\_\_\_\_\_ Gastrointestinal \_\_\_\_\_ Nervous System \_\_\_\_\_ Neurological (Stroke)

\_\_\_\_\_ Ear / Nose / Throat \_\_\_\_\_ Arthritis \_\_\_\_\_ Cancer

\_\_\_\_\_ Cardiovascular \_\_\_\_\_ Skin Disorder / Disease \_\_\_\_\_ Thyroid Disease

\_\_\_\_\_ Respiratory \_\_\_\_\_ Diabetes (Sugar) \_\_\_\_\_ Kidney Disorder

\_\_\_\_\_ Memory Loss \_\_\_\_\_ Heart Disease \_\_\_\_\_ Seasonal Allergies

\_\_\_\_\_ Headaches \_\_\_\_\_ Hypertension \_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgical Procedures and Significant Injuries: (Dates) Past Eye Surgery / Injuries (Dates)**
­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |
| 6. |  |  |
| 7. |  |  |
| 8. |  |  |
| 9. |  |  |
| 10 |  |  |

 **Current Medication Dosage How often**

**FAMILY HISTORY (F/FATHER; M/MOTHER; S/SIBLING; GP/GRANDPARENT)**

\_\_\_\_\_ Arthritis \_\_\_\_\_ Thyroid Disease \_\_\_\_\_ Amblyopia (Lazy Eye) \_\_\_\_\_ Macular Degeneration

\_\_\_\_\_ Migraines \_\_\_\_\_ Hypertension \_\_\_\_\_ Cancer \_\_\_\_\_ Retinal Detachment

\_\_\_\_\_ Emphysema \_\_\_\_\_ Skin Disease / Disorder \_\_\_\_\_ Cataract \_\_\_\_\_ Other Retinal Disease

\_\_\_\_\_ Stroke \_\_\_\_\_ Heart Disease \_\_\_\_\_ Glaucoma \_\_\_\_\_ Diabetes

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Signature Date

**CATARACT PATIENT LIFESTYLE QUESTIONNAIRE**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Here at Laser Eye Surgery of Erie, we strive to provide the best quality of care and customized vision solutions for our patient. This checklist will assist us in providing the best treatment suitable for your lifestyle.

1. **Are you interested in Laser Cataract Surgery?** \_\_\_\_\_ YES \_\_\_\_\_ NO
2. **How important would it be for you to be free of glasses for your daily activities?**

 \_\_\_\_\_ Very Important

 \_\_\_\_\_ Moderately Important

 \_\_\_\_\_ Not Important

 \_\_\_\_\_ I only want what my insurance will cover

1. **Does your work or livelihood require you to drive at night?** \_\_\_\_\_ YES \_\_\_\_\_ NO
2. **Please check the ONE activity below that you would most like to perform without glasses. Remember that you will likely need glasses for the other activities.**

 \_\_\_\_\_ Reading \_\_\_\_\_ Computer \_\_\_\_\_ Watching TV

 \_\_\_\_\_ Activities around the house \_\_\_\_\_ Driving \_\_\_\_\_ Golf

1. **What activities do you enjoy?**

\_\_\_\_\_ Crosswords Puzzles \_\_\_\_\_ Cooking \_\_\_\_\_ Swimming

\_\_\_\_\_ Painting \_\_\_\_\_ Needlepoint \_\_\_\_\_ Reading

\_\_\_\_\_ Wood Working \_\_\_\_\_ Tennis \_\_\_\_\_ TV

\_\_\_\_\_ Golf \_\_\_\_\_ Gardening \_\_\_\_\_ Arts and Crafts

1. **How would you describe your personality?**

 \_\_\_\_\_ Perfectionist \_\_\_\_\_ In Between \_\_\_\_\_ Easy Going

Payment Policy

Thank you for choosing us as your Ophthalmology provider. Some of our patients have had questions regarding patient and insurance responsibility for services rendered, so we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

**NOTE:** The amount you pay today for your office visit depends on several factors including:

1. Whether you are a New Patient or you’ve visited our office before
2. The complexity of your complaint
3. The doctor’s examination

Often, the doctor will recommend that a specific procedure be performed during a visit. The costs of these procedures are separate and not included in your office visit. You can refuse any treatment and we can provide you with an estimate prior to any treatment being performed.

**Please read the information below:**

**INSURANCE:** We participate in most insurance plans, including Medicare. If you are ***NOT*** insured by a plan, we do business with, payment in full is expected at the time services are rendered. If you ***ARE*** insured by a we do business with, but ***DO NOT*** have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. ***KNOWING YOUR INSURANFE BENEFITS IS YOUR RESPONSIBILITY*.** Please contact your insurance company with any questions you may have regarding your coverage.

**CO-PAYMENTS AND DEDUCTIBLES:** All co-payments and deductibles must be paid at the time of service. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.

**NON-COVERED SERVICES:** Please be aware that some of the services you receive may be ***NON-COVERED*** or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time they are rendered.

**PROOF OF INDURANCE:** All patients must complete our patient information packet before seeing one of our doctors. We must obtain a copy of your driver’s license and current valid insurance to provide proof of insurance. If you fail to provide us with the ***CORRECT insurance information in a timely manner***, you may be responsible for the balance of a claim.

**CLAIMS SUBMISSION:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Please be aware that the ***balance of your claim is your responsibility whether or not your insurance company pays your claim.***

**COVERAGE CHANGES:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. ***If your insurance company foes not pay your claim, the balance will automatically be billed to you.***

**NONPAYMENT:** If your account is ***over*** 120 days past due, you will receive a letter stating that you have ***10*** days to pay your account in full. Partial payments will not be accepted unless otherwise agreed upon. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency and you will be ***unable*** to schedule additional non-emergent appointments until this balance is paid in full.

**SELF-PAY (NO INSURANCE COVERAGE):**  Our practice offers a discount equal to what Medicare allows if self-pay patients pay at the time of service. If you do not pay then, we are unable to offer you that discount. The amount our office charges for self-pay office visits is based on fees set forth each year by the federal government. We are not allowed, by law, to charge less then the federal reimbursement fee. To learn more about those fees visit [www.cms.gov/home/medicare.asp](http://www.cms.gov/home/medicare.asp). You are expected to pay your bill in full at the time of service. If this is not possible, you may consider a payment plan. To do this you must sign a ***SELF-PAY/PRIVATE PAY AGREEMENT*** form in our office.

**You may pay your bill:**

In our office
Mail your Payment
Calling over the Phone (by giving a credit or debit card over the phone)

**We Accept:**

Cash VISA
Check MasterCard
American Express Discover

Our staff is instructed to make every effort to clarify any questions concerning payment. If you need further information about any of these policies, or about the amount you will be asked to pay today, ***please ask to speak with our billing department.***

*While every attempt is made to provide up-to-date information, Laser Eye Surgery does not ensure the accuracy of the information provided. Since health or medical insurance reimbursement is affected by many factors, Laser Eye Surgery makes no representation or guarantee that a patient will be successful in obtaining insurance reimbursement or any other payment.*

*Laser Eye Surgery recognizes that medical information is confidential and will maintain the privacy or your medical information. Information will only be used and disclosed in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPPA). However, many insurance companies require that medical information be submitted with claims to determine medical necessity.*

**By signing below, I agree to the following:**I request that payment of authorized Medicare benefits be made on my behalf to Laser Eye Surgery of Erie for any services furnished for me by the physicians. I authorize any holder of Medical information about me to release to the Health Care Financing Administration and its agents, any information to determine these benefits payable for related services.

I understand that if my insurance company does not accept assignment of benefits, all correspondence and payment for service may be sent directly to me. I agree when such payments are received by me, I will make payment on my bill with credit card, personal check, or by endorsing the insurance check “Pay to the Order of Laser Eye Surgery” within ten (10) days. I agree to notify Laser Eye Surgery immediately of any changes to my insurance coverage or if I change my insurance company. I consent to the release of all information, including medical records to o or from my physician and to or from the insurance company, for the purposes of healthcare management and/or for processing of medical claims.

1. I also request payment of government benefits to Laser Eye Surgery of Erie who accepts assignment.
2. I authorize payment of medical benefits to Laser Eye Surgery
3. I understand the HIPPA Privacy Policy of Laser Eye Surgery

**SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NONDISCRIMINATORY POLICY**

Laser Eye Surgery of Erie has agreed to comply with the provision of the Federal Civil Rights Act of 1964 and all requirements imposed pursuant thereto to the end that no person shall, on the grounds of race, color, nation origin, ancestry, age, sex, religious creed, or disability, be excluded from participation in, be denied benefits of, or otherwise be subject to discrimination in the provision of any care or service.

**CIVIL RIGHTS COMPLIANCE**

Laser Eye Surgery of Erie complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Laser Eye Surgery of Erie does not exclude people or treat them differently because of race, color, national origin, age, disability or sex, sexual orientation, gender preference.

**LANGUAGE ASSISTANCE**

Laser Eye Surgery of Erie provides free aids and services to people with disabilities to communicate effectively with us, such as:

Qualified sign language interpreters

Written information and other formats can be requested and made readily available, other formats may include:
 Large Print
 Audio

Laser Eye Surgery of Erie provides free language services to people whose primary language is not English, such as:
 Qualified Interpreters
 Information written in other languages

**THESE SERVICES MUST BE REQUESTED 1 WEEK PRIOR TO YOUR APPOINTMENT**

I understand that if I believe that Laser Eye Surgery of Erie has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, I can file a grievance with: The Bureau of Equal Opportunity, Room 223, Health and Welfare Building, P.O. Box 2675 Harrisburg, PA 17105-2675, (717)787-1127, TTY (800) 654-5484, Fax (717)772-4366, or email – RA-PWBEOAO@pa.gov.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Signature Date

**Refractive Surgery Patient Lifestyle Questionnaire**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about Laser Eye Surgery of Erie?**
[ ]  Internet [ ]  Referring Doctor [ ]  Family/Friend [ ]  Social Media (Facebook/Instagram/YouTube) [ ]  TV/Radio

If you were referred, please provide who referred you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are you considering laser vision correction? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When are you looking to have the procedure?**
[ ]  0-3 months [ ]  3-6 months [ ]  6-12 months [ ] 1 year or more

**When was your last eye exam?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has your prescription been stable for at least one year?**
[ ]  Yes, 1+ years [ ]  No, slight changes [ ]  No, script changes drastically at each exam

**Do you wear glasses?** \_\_\_\_\_ Yes \_\_\_\_\_ No **At what age did you start wearing them?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When do you wear your glasses?**
[ ]  All the time [ ]  Sometimes [ ]  Only for distance [ ]  Only for reading [ ]  Only for computer

**Do you wear contacts?** \_\_\_\_\_ Yes \_\_\_\_\_ No **At what age did you start wearing them?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How often do you wear your contacts?** **If contacts, what kind?**
[ ]  All the time [ ]  Sometimes [ ]  Never [ ]  Soft [ ]  Soft Toric [ ]  Gas Perm (RGP) [ ]  Hard

**How satisfied are you with your glasses or contacts?** (circle) Best 5 4 3 2 1 Worst

**Do you have a history of:**
[ ]  Keratoconus [ ]  Glaucoma/Cataracts [ ]  Keloids [ ]  Herpes Simplex [ ]  Rheumatoid Arthritis [ ]  Collagen Vascular Disease [ ]  Thyroid Condition

**Check the following activities you do on a regular basis:**
[ ]  Drive – Daytime [ ]  Drive – Nighttime [ ]  Cellphone Use [ ]  Paperwork/Writing/Reading [ ]  Computer Use
[ ]  Photography [ ]  Play a Musical Instrument [ ]  Active in Sports (ex: Tennis/Golf/Boxing) [ ]  Paint/Draw
[ ]  Needlepoint/Sew [ ]  Play Cards/Games [ ]  Watch Television [ ]  Watch Spectator Sports [ ]  Cook/Read Recipes
[ ]  Hunt/Fish [ ]  Shopping [ ]  Exercise [ ]  Cycling [ ]  Water Sports [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When scheduling your LASIK procedure, which of the following are the most important factors in your decision to proceed with surgery? (1 being the most important)**

\_\_\_ Technology \_\_\_ Comfort \_\_\_ Cost \_\_\_ Surgeon Experience \_\_\_ Schedule Flexibility \_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Signature Date