LASER EYE SURGERY OF ERIE

For Office Use Only:
Date Received: _____
Reviewed By: _____

Name: _____ Date of Birth: _____ Age: _____
Last Name First Name Middle

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-Mail: _____

Marital Status: Married: ___ Widowed: ___ Single: ___ Divorced: ___

Please specify ethnicity:
___Hispanic or Latino
___Not Hispanic or Latino

Please specify race:
___American Indian/Alaska Native
___ Native Hawaiian / Other Pacific Islander
___Black/African American
___ White
___ Not Disclosed
___ Asian

Preferred Language: _____

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: _____

PRIMARY INSURANCE

Name of Insurance: _____ I.D. #: _____

Insured's Name: _____ Group #: _____

Insured's Date of Birth: _____ Employer's Name: _____

SECONDARY INSURANCE

Name of Insurance: _____ I.D. #: _____

Insured's Name: _____ Group #: _____

Insured's Date of Birth: _____ Employer's Name: _____

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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? _____

___ Tired Eyes / When did this start? _____

___ Double Vision / When did this start? _____

___ Burning / When did this start? _____

___ Redness / When did this start? _____

___ Itching / When did this start? _____

___ Loss of Vision / When did this start? _____

___ Floaters or Spots / When did this start? _____

___ Dryness / When did this start? _____

___ Blurred Vision at Distance / When did this start? _____

___ Blurred Vision at Near / When did this start? _____

___ Excess Tearing/Watering / When did this start? _____

___ Glare/Light Sensitivity / When did this start? _____

___ Amblyopia (Lazy Eye) / When did this start? _____

___ Sandy/Gritty Feeling / When did this start? _____

___ Drooping Eyelid / When did this start? _____

___ Infection of Eye/Lid / When did this start? _____

___ Crossed Eyes / When did this start? _____

___ Mucous Discharge / When did this start? _____

___ Fluctuation Vision / When did this start? _____

___ Distorted Vision (Halos) When did this start? _____

___ Eye Pain or Soreness / When did this start? _____

___ Loss of Side Vision / When did this start? _____

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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)

_____
_____
_____
_____
_____

Current Medication	Dosage	How often
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10		

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

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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.

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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. 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.

We Accept:		**You may pay your bill:**
Cash	VISA	In our office
Check	MasterCard	Mail your Payment
American Express	Discover	Calling over the Phone (by giving a credit or debit card over the phone)

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:** _____