Adventures
IN EYE CARE

Patient Health Information

Eye History:

Date of Last Exam_____ **Previous Eye Doctor**_____
Do you currently wear glasses?_____ **Do you wear contact lenses?**_____

Reason for today's visit?_____

_____

_____

Have you or a family member experienced, or been treated for, and of the following? (Circle all that apply)

Cataracts yes no family **Glaucoma** yes no family **Macular Degeneration** yes no family
Lazy eye yes no family **Lasik** yes no family **Retinal Detachment** yes no family
Eye Injury yes no family **Eye Surgery** yes no family

Are you currently experiencing, or have you experienced, any of the following? (Circle all that apply)

Blurry Vision (near or distance) Burning Discharge Double Vision Double Vision
Dryness Excessive Tearing/Watering Eye Infection Eye Pain Floaters/Spots
Halos Headaches Itching Light Flashes Light Sensitivity
Pressure Redness Sandy/Gritty Feeling

Medical History:

Have you or a family member experienced, or been treated for, any of the following? (Circle all that apply)

Allergies yes no family **Arthritis** yes no family **Asthma** yes no family
Blood/Lymph Disorder yes no family **Cancer** yes no family **Diabetes** yes no family
ENT Disorders yes no family **GI Conditions** yes no family **Heart Disease** yes no family
High Blood Pressure yes no family **High Cholesterol** yes no family **Kidney Disease** yes no family
Neurological Conditions yes no family **Psychiatric Disorders** yes no family **Seizures** yes no family
Skin Conditions yes no family **Stroke** yes no family **Thyroid Dysfunction** yes no family

Current Medications (prescription, OTC, and supplements):

_____

_____

_____

Medication Allergies_____

Do you currently or have you ever smoked?_____ **How long ago did you quit?**_____

Are you pregnant or nursing?_____

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New Patient Information

Patient Information:

Name (Last, First, M)_____

Address_____City_____State_____Zip_____ Sex: ___M___F

Phone # (Home)_____(Cell)_____(Work)_____

Social Security#_____-_____-_____ Drivers Licenses #_____

Date of Birth_____ Race (optional)_____Hispanic/Latino ____Yes____No

Email Address_____

Occupation_____ Employer_____

Parent/Guardian Information (if patient is under 18 – must be accompanied by parent or legal guardian)

Name (Last, First, M)_____

Mailing Address_____City_____State_____Zip_____

Phone # (Home)_____(Cell)_____(Work)_____

Social Security#_____-_____-_____ Drivers License #_____

Date of Birth_____Email Address_____

Alternate/Emergency Contact: (Is there anyone we can contact regarding your health and account information if you are unable to be reached?)

1. Name (Last, First)_____ Phone #_____

Can we disclose account information:_____Yes_____No, health information:_____Yes_____No

2. Name (Last, First)_____ Phone #_____

Can we disclose account information:_____Yes_____No, health information:_____Yes_____No

Insurance Information:

Insurance Company (Primary):_____Subscriber Name:_____

Subscriber ID:_____Group ID:_____

Subscriber Birthday:_____Patient Relation to Subscriber_____

Insurance Company (Secondary):_____Subscriber Name:_____

Subscriber ID:_____Group ID:_____

Subscriber Birthday:_____Patient Relation to Subscriber_____

HIPAA Notice of Privacy Practices: Adventures In Eye Care is required by law to maintain the privacy of, and provide individuals with, this notice of legal duties and privacy practices with respect to protected health information. Signature below is only acknowledgement that you have received this notice of our Privacy Practices:

Patient Name_____Signature (patient/guardian)_____Date_____

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Statement of Financial Responsibility

Patient Name: _____ Date: _____

Adventures In Eye Care appreciates the confidence you have shown in choosing us to provide for your vision care needs. The service you have elected to participate in implies a financial responsibility on your part. This Responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any co-payment at the time of service and on receipt of a bill for any deductible/coinsurance as determined by your contract with your insurance carrier. Many insurance may have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, regardless of the reason for the denial, you will be responsible for the balance in full. For your convenience, we accept cash, checks, and most major credit cards. Payment is expected by payment due date on your monthly patient statement.

Authorize and Acknowledge: I understand it is my responsibility to confirm my coverage with my insurance and that Adventures In Eye Care will bill my insurance as a courtesy to me. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. Amounts not paid by insurance are the patient's responsibility. I also acknowledge that nay eyewear purchased is custom made and custom ordered. There will be no refund for services or products and orders cannot be cancelled once they have been placed. Orders not picked up within 60 days may be returned and deposits will be forfeited.

I, the patient/guardian, have accurately and truthfully completed the patient information. I agree that all fees incurred are my responsibility regardless of insurance coverage.

Patient/Guardian Signature_____ Date_____

Adventures IN EYE CARE

Adventures In Eye Care (AIEC) Financial Policies
Please Read and Initial

PATIENT NAME_____ DATE_____

- If proof of insurance/eligibility cannot be provided, payment will be due in full. _____
- AIEC will collect any deductibles, copay, or coinsurance on the date of service. _____
- Insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-pays, covered charges, secondary insurance, "usual and customary" charges, etc. _____
- Please be advised, if you are here for a routine eye exam and have medical eye problems you want to discuss with the provider during your routine eye exam, this could result in an additional charge, which may not be covered by your vision insurance. For clarification or to update the reason for your visit, please see the front desk. _____
- Eyeglasses and contact lenses are custom made and custom ordered for you, therefore, are nonrefundable. _____
- Balances on your account must be paid in full before you will be seen again unless a payment arrangement has been made with billing personnel. If you need an arrangement, please contact the billing department in a timely manner as any claim over 90 days will be due in full. _____
- Statements are not generated for an amount due of less than $5.00; please watch your insurance explanations to see if you owe a balance. _____
- AIEC is in network with the following insurances: Medicare, Medicaid, Blue Cross, Tricare, Aetna, Cigna, and VSP. If your insurance is not one of these, please be aware your claim(s) may be processed as "out of network" or we may not be able to bill them at all, i.e. Spectera and Eyemed. _____
- Delinquent account (>90 days) are subject to collections processes which may include the account being transferred to Cornerstone Credit Services (CCS). Patients whose accounts have been sent to CCS will be reviewed for possible discharge from the clinic. _____
- AIEC will charge a fee of $30.00 for any checks returned at NSF. The patient's account will be flagged until the debt has been repaid. _____
- Any appointment cancelled less than 24 hours prior to the scheduled appointment time and no-shows will incur a $50.00 cancellation fee. After three missed appointments, an account will be reviewed for discharge from the practice. _____
- It is important to clarify the reason for your visit. Please do this at the time of your visit as it is AIEC's policy to not change a diagnosis code after the visit. Do feel free to clarify/confirm what diagnosis will be used with your provider before you leave the office. _____