EYECARE REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

3 PHONE NUMBERS

Home (_____) _____ Cell (_____) _____ Spouse's Work Phone (_____) _____ Ext _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home (_____) _____ Cell (_____) _____ Work Phone (_____) _____ Ext _____

4 EYE HEALTH HISTORY

Physician's Name _____

Date of last visit _____

Date of last eye exam _____

Name of doctor _____

Do you wear glasses? ☐ Yes ☐ No

☐ All the time ☐ Occasionally
☐ Reading ☐ Driving ☐ TV

Do you wear contacts? ☐ Yes ☐ No

Type _____ Hours/Day _____

Describe any problems you have with your contacts _____

_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bloodshot Eyes	☐ Yes ☐ No	Floaters or Spots	☐ Yes ☐ No
Blurred Vision – Distance	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Blurred Vision – Near	☐ Yes ☐ No	Headaches	☐ Yes ☐ No
Burning Eyes	☐ Yes ☐ No	Itching Eyes	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Light Sensitive	☐ Yes ☐ No
Color Vision, Poor	☐ Yes ☐ No	Loss of Vision	☐ Yes ☐ No
Crossed Eyes	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No
Discharge from Eyes	☐ Yes ☐ No	Night Vision, Poor	☐ Yes ☐ No
Dizzy Spells	☐ Yes ☐ No	Red Eyes	☐ Yes ☐ No
Double Vision	☐ Yes ☐ No	Seeing Halos	☐ Yes ☐ No
Dry Eyes	☐ Yes ☐ No	Seeing Flashes	☐ Yes ☐ No
Eye Infection	☐ Yes ☐ No	Temporary Loss of Vision	☐ Yes ☐ No
Eye Injury	☐ Yes ☐ No	Twitching Eyelid	☐ Yes ☐ No
Eye Strain	☐ Yes ☐ No	Vision Poor	☐ Yes ☐ No
Fainting Spells, Blackouts	☐ Yes ☐ No	Watering Eyes	☐ Yes ☐ No

5 HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself		Family Members			Yourself		Family Members	
AIDS/HIV	☐ Yes	☐ No	☐ Yes	☐ No	Hepatitis (Type_____)	☐ Yes	☐ No	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	☐ Yes	☐ No	Lazy Eye	☐ Yes	☐ No	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	☐ Yes	☐ No	Lupus	☐ Yes	☐ No	☐ Yes	☐ No
Bleeding	☐ Yes	☐ No	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	☐ Yes	☐ No
Blindness	☐ Yes	☐ No	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	☐ Yes	☐ No	Poor Color Vision	☐ Yes	☐ No	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	☐ Yes	☐ No	Retinal Disease	☐ Yes	☐ No	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	☐ Yes	☐ No	Shingles	☐ Yes	☐ No	☐ Yes	☐ No
Drug Sensitivity	☐ Yes	☐ No	☐ Yes	☐ No	Skin Conditions	☐ Yes	☐ No	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	☐ Yes	☐ No	Thyroid Conditions	☐ Yes	☐ No	☐ Yes	☐ No
Eye Surgery	☐ Yes	☐ No	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	☐ Yes	☐ No	Turned Eye	☐ Yes	☐ No	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	☐ Yes	☐ No	Are you pregnant? _____	Number of children_____			
Heart Condition	☐ Yes	☐ No	☐ Yes	☐ No	Tobacco use _____	Alcohol use_____			

MEDICATIONS

List any medications you are currently taking, including eye drops:

_____

_____

Pharmacy Name_____

Phone (_____)_____

ALLERGIES

List your allergies to medications or other substances:

_____

_____

_____

_____

6 MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

_____ for any services furnished to me by that provider.

Name of Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Beneficiary, Guardian or Personal Representative — Date

_____ _____

Please print name of Beneficiary, Guardian or Personal Representative — Relationship to Beneficiary

Medical Information Release Form
HIPAA Release Form

_____ Date of Birth:_____/_____/_____

Full Name of Patient

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Name_____Relationship to Patient_____

Name_____Relationship to Patient_____

Name_____Relationship to Patient_____

Name_____Relationship to Patient_____

[ ] Information is not to be released to anyone.

- This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
- This authorization shall be in force and effect until nine (9) months after my death or until terminated by me in writing.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

BREACH NOTIFICATION

It is our duty to determine whether a breach of information has occurred. In the unlikely event of a breach of your personal information, we are obligated and will promptly inform you of such an event.

_____ Date:_____/_____/_____
Signature of Patient or Guardian if Minor

_____ Date: _____/_____/_____
Signature of Witness

I have been given a copy of Notice of Privacy Practices: _____ yes _____ no

***Additional information of Notice of Privcy Practices available on request*

Financial Agreement

Thank you for choosing Baldwin Eye Clinic as your vision care provider. Please take a moment to read the following, initial each section and sign and date the bottom of this form.

If applicable, insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances that are not paid within 45 days may be billed to you. Please keep statements and follow-up with your insurance carrier to ensure prompt payment. Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility.

Please remember your vision/medical policy is a contract between you and your insurance company. *We are not a party to that contract. It is physically impossible for us to have knowledge and keep track of every aspect of your policy. It is up to you to contact your insurance and inquire as to what your insurance benefits are.*

As a courtesy to you, our office will process your insurance claims. When filing medical insurance, we will do our best to give you a very close ***ESTIMATE*** of what your charges will be on the date of service. There may be copays and/or deductibles that could be applied once the insurance claim is filed that we are not aware of. We must emphasize that as your eye care provider, our relationship is with you, our patient, not with your insurance company.

Medical coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums, which are your responsibility. Some companies arbitrarily select certain services they will cover. It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy. ***Coverage issues can only be addressed by your employer or group plan administrator***. We cannot act as a mediator with the carrier or your employer. Please be aware some or perhaps all of the services provided may or may not be covered by your medical policy; therefore, any balance is your responsibility whether or not your medical policy pays any portion.

Patients are asked to confirm their appointments at least 24 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to keep your appointment may result in a charge for the time reserved, as this time could be given to another patient in need.

_____ It is required to confirm an appointment with a specialist at least 24 hours in advance. If a 24-hour notice is not given, a cancellation fee of a minimum $30 will apply

_____ There will be a minimum fee of $35 for any checks returned as Non-Sufficient Funds (NSF).

_____ I understand that and agree to be responsible for payment of all services rendered on my behalf or my dependents' behalf.

_____ I understand that copays and non covered charges are due in full at the time of service.

_____ I understand that all charges are due in full at the time of service if I do not have insurance.

Patient/Guarantor Signature : _____

BALDWIN EYE CLINIC

27900 North Main Street
Daphne, AL. 36526
251-621-1211 **Date_____**

PLEASE READ CAREFULLY!!

Thank you for choosing our office for your professional contact lens fitting and evaluation. Your total contact lens fee will consist of charges for professional services in addition to your exam.

PROFESSIONAL SERVICES

Professional fee + Fitting fee + Contact lens = Total due at time of visit

YEARLY CONTACT LENS FEE $50.00

CONTACT LENS FITTING FEE AND RE-FITTING FEE- (SINGLE VISION) $70.00

CONTACT LENS FITTING FEE- (GAS PERM, BIFOCAL, TORIC OR MONOVISION) $110.00

Included in your contact lens fitting is a ONE trial pair of contact lenses, instruction on insertion and removal of lens, caring of your contact lens, a care kit and follow up visit. Once the follow up visit has taken place, you may purchase contact lenses. CONTACT LENS MATERIALS ARE NOT INCLUDED IN THE PRICE OF THE EXAM OR FITTING. THIS IS AN OUT OF POCKET EXPENSE. OUT OF POCKET CHARGES MAY BE DIFFERENT IF FILING ON INSURANCE.

Follow up visits must be completed within 30 days or there will be an additional contact lens fitting fee.

All professional fees and materials are due at the time of the exam…If you choose not to continue with the contact lenses or change to a different type, the money paid for services only, will go towards the purchase of eye glasses or a different type of contact lens. NO MONEY WILL BE REFUNDED. NO CHARGES FILED TO INSURANCE WILL BE REVERSED.

If you currently wear contact lenses the above fee schedule still applies.

****SPECIAL NOTE:** We do not COD (cash on delivery) contact lens orders. We require payment in full before all orders are placed. Also, please make arrangements to place your order before you run out of contacts and/or before your prescription expires as we will no longer be able to supply you with any trial lenses.*

***Exchange/Return Policy:** We will exchange unopened/not damaged—to include no writing on boxes and expiration date no less than 1 year to expiring for exchange for in stock items only. Boxes must be in resalable condition. Any products that have to be returned to the manufacturer must be within 30 days of the original purchase date and a $5.00 per box restocking fee will apply. We will not exchange or credit any opened boxes.*

I AGREE TO THE ABOVE CONTACT LENS FITTING AGREEMENT

_____ _____

Printed Name of Patient **Patient or Responsible Party Signature**