Epic Vision Eye Centers

Demographic Information

PATIENT INFORMATION

□ Mr. □ Mrs. □ Ms. □ Miss □ Dr. Patient Name _____
(Last) (First) (MI)

Preferred Name _____ Date of Birth _____/_____/_____ Gender □ Male □ Female

Social Security# _____
*(**required for insurance submission**)*

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

Language ☐ English ☐ Spanish ☐ Other _____

Home Phone (_____) _____ - _____

Race ☐ White ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Declined ☐ Hispanic ☐ Indian ☐ Native Hawaiian/Pacific Island ☐ Other _____

Work Phone (_____) _____ - _____

Ethnicity ☐ Asian ☐ Caucasian/White ☐ Declined ☐ Hispanic/Latino ☐ Middle Eastern ☐ Native Hawaiian/Pacific Island ☐ Other _____

Cell Phone (_____) _____ - _____

Address _____
(Street) (City) (State) (Zip)

Employer _____ Occupation _____ □ Retired □ Full Time □ Part Time

Email _____ Preferred Notification □ Text □ Phone □ Email

GUARANTOR INFORMATION - FINANCIALLY RESPONSIBLE PARTY (UNDER 18) / PRIMARY INSURANCE HOLDER (IF DIFFERENT FROM ABOVE)

□ Mr. □ Mrs. □ Ms. □ Miss □ Dr. Name _____
(Last) (First) (MI)

Social Security# _____ Date of Birth _____/_____/_____ Gender □ Male □ Female
*(**required for insurance submission**)*

Home Address _____
(Street) (City) (State) (Zip)

Phone (_____) _____-_____ (_____) _____-_____ (_____) _____-_____
(Home) (Work) (Cell)

Employer _____ Occupation _____

PRIMARY INSURANCE - PRESENT INSURANCE CARD(S) TO FRONT DESK AT YOUR APPOINTMENT

Name of Policy Holder _____ Date of Birth _____ /_____/_____
(Last) (First) (MI)

Social Security/Member ID # _____ Relationship to Patient _____

Name of Insurance Co. _____ Phone of Insurance Co. (_____) _____ - _____

Plan Name _____ Group # _____ Effective Date _____ /_____/_____

Address of Insurance Co. _____
(Street) (City) (State) (Zip)

SECONDARY / VISION INSURANCE - PRESENT INSURANCE CARD(S) TO FRONT DESK AT YOUR APPOINTMENT

Name of Policy Holder _____ Date of Birth _____ /_____/_____
(Last) (First) (MI)

Social Security/Member ID # _____ Relationship to Patient _____

Name of Insurance Co. _____ Phone of Insurance Co. (_____) _____ - _____

Plan Name _____ Group # _____ Effective Date _____ /_____/_____

Address of Insurance Co. _____
(Street) (City) (State) (Zip)

Epic Vision Eye Centers

Patient Health History

Date: _____

Name: _____ Date of Birth: _____

Previous Eye Doctor: _____ Last Exam: _____ / _____ (Month / Year)

Current Vision Specialist: _____ Last Exam: _____ / _____ (Month / Year)

Current Medical Doctor: _____ Last Exam: _____ / _____ (Month / Year)

Do you wear glasses? Y / N If yes, how old are your current glasses? _____ Months / Years

How many glasses do you currently use? _____ Type: ☐ Full Time ☐ Computer ☐ Reading ☐ Other_____

Do you wear contact lenses? Y / N If yes, how old are your present pair? _____ Months / Years Comfortable? Y / N

What type of contacts do you currently wear? ☐ Soft – Daily ☐ Soft – 2week or Monthly ☐ Extended Wear ☐ Rigid

Do you perform fine or close-up work? Y / N

At work, are you outdoors full or part time? Y / N

At work, do you use a computer full time? Y / N

Is safety protection a concern? Y / N

Are you pregnant and/or nursing? Y / N

Do you have trouble reading road signs? Y / N

Are you bothered by oncoming headlights? Y / N

Are you bothered by glare from overhead lighting? Y / N

Are you bothered by glare from computer screens? Y / N

Are you sensitive in sunlight? Y / N

What hobbies/recreational activities do you enjoy? _____

Patient History:

Systemic Surgeries

- ☐ Appendectomy
- ☐ Gallbladder
- ☐ Hysterectomy
- ☐ Mastectomy
- ☐ Thyroidectomy

Ocular Conditions

- ☐ Blurred Vision
- ☐ Dryness
- ☐ Double Vision
- ☐ Flashes
- ☐ Floaters
- ☐ Vision Loss
- ☐ Crossed Eyes
- ☐ Lazy Eyes
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Color Deficiency
- ☐ Macular Degeneration
- ☐ Itching
- ☐ Burning
- ☐ Redness

Ocular Surgeries

- ☐ Cataracts - Right, Left, Both
- ☐ Glaucoma
- ☐ Retinal Procedure
- ☐ LASIK
- ☐ YAG

Other Surgeries/Conditions: _____

Medications – list any medication + dose (including eye drops, oral contraceptives, vitamins, and over the counter):

_____

_____

Allergies: To medications? Y / N If yes, explain: _____

Food or environmental? Y / N If yes, explain: _____

Family History – Have any of your relatives, living or deceased, had any of these conditions?
Relative = mother, father, sister, brother, daughter, son, maternal/paternal grandmother/grandfather, aunt, uncle or distant relative

Ocular	Yes	No	Unsure	Relationship	Systemic	Yes	No	Unsure	Relationship
Blindness	☐	☐	☐	_____	Arthritis	☐	☐	☐	_____
Cataract	☐	☐	☐	_____	Cancer	☐	☐	☐	_____
Corneal Disease	☐	☐	☐	_____	Diabetes	☐	☐	☐	_____
Corneal Transplant	☐	☐	☐	_____	Heart Disease	☐	☐	☐	_____
Crossed / Lazy	☐	☐	☐	_____	High Blood Pressure	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____	Lupus	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____	Stroke	☐	☐	☐	_____
Retinal Detachment / Disease	☐	☐	☐	_____	Thyroid Disease	☐	☐	☐	_____

Social History *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor.*

Do you use tobacco products? Y / N If yes, type / amount / how long? _____

Do you drink alcohol? Y / N If yes, type / amount / how long? _____

Do you use recreational drugs? Y / N If yes, type / amount / how long? _____

Have you had a blood transfusion? Y / N If yes, when? _____

Have you ever been exposed / infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ No, I have not.

Review Of Systems – Do you currently, or have you ever had any problems in the following areas:

System	Yes	No		System	Yes	No
Cardiovascular				**Immunologic**		
Cardiovascular Disease	☐	☐		Herpes - Simplex / Zoster	☐	☐
Elevated Cholesterol	☐	☐		Histoplasmosis	☐	☐
Hypertension	☐	☐	Onset _____ Meds? Y / N	Lyme Disease	☐	☐
Stroke	☐	☐	When _____ Meds? Y / N	Sjogren's Syndrome	☐	☐
Constitutional				Tuberculosis	☐	☐
Blackouts	☐	☐		**Integumentary**		
Car Sickness	☐	☐		Acne	☐	☐
Dizziness	☐	☐		Rosacea	☐	☐
Fatigue	☐	☐		Dry Skin	☐	☐
Excess Thirst	☐	☐		Lupus	☐	☐
Nausea	☐	☐		Rash / Hives	☐	☐
Endocrine				**Musculoskeletal**		
Diabetes - Type 1	☐	☐	Onset _____ Meds? Y / N	Arthritis	☐	☐
Diabetes - Type 2	☐	☐	Onset _____ Meds? Y / N	Osteoporosis	☐	☐
Pituitary Disorder	☐	☐		Scoliosis	☐	☐
Renal Disease	☐	☐		**Neurological**		
Thyroid Disorder	☐	☐		Bell's Palsy	☐	☐
Gastrointestinal				Brain Tumor	☐	☐
Acid Reflux	☐	☐		Dyslexia	☐	☐
Inflammatory Bowel	☐	☐		Epilepsy	☐	☐
Gall Stones	☐	☐		Headache / Mirgaines	☐	☐
Diarrhea	☐	☐		Multiple Sclerosis	☐	☐
Jaundice	☐	☐		Nystagmus	☐	☐
Ulcer	☐	☐		Parkinson's Disease	☐	☐
Genitourinary				Vertigo	☐	☐
Bladder Infection	☐	☐		**Psychiatric**		
Kidney Stones	☐	☐		ADD	☐	☐
Pregnancy	☐	☐		Alcoholism	☐	☐
Menopause	☐	☐		Alzheimer's Disease	☐	☐
STD _____	☐	☐		Anxiety	☐	☐
Cancer - Uterine / Prostate	☐	☐		Autism	☐	☐
Ear / Nose / Throat				Brain Damage	☐	☐
Chronic Cough	☐	☐		Bi - Polar	☐	☐
Dry Mouth	☐	☐		Dementia	☐	☐
Cold	☐	☐		Depression	☐	☐
Hearing Loss	☐	☐		Insomnia	☐	☐
Encephalitis	☐	☐		Learning Disability	☐	☐
Hematologic / Lymphatic				**Respiratory**		
Breast Cancer	☐	☐		Asthma	☐	☐
Leukemia	☐	☐		COPD	☐	☐
Sickle Cell Disease	☐	☐		Emphysema	☐	☐
Temporal Arteritis	☐	☐		Lung Cancer	☐	☐
Hematologic Disorder	☐	☐		Pneumonia	☐	☐

Financial Policy

In an effort to better serve our patients and keep costs to a minimum, our office maintains the following financial policy:

- Accepted forms of payment include:
  - Cash
  - Check
  - Credit card
  - Flex spending card
  - Care credit

- Payment due at time of service:
  - Materials (glasses and contact lenses) – at order placement
  - Exams (co-pay/non-covered services/cash pay) – on exam date

- Insurance filing:
  - As a courtesy Epic Vision will file your vision or medical claim on your behalf
  - Our office follows the explanation of benefits when processing your claim based on your insurance companies guidelines

- Patient responsibility:
  - You will be responsible for any balance that your insurance policy did not cover
  - Balances must be resolved within 30 days of the mailing of your outstanding balance statement
  - Overdue accounts in excess of 90 days may be referred to our collection agency

- Returned check
  - You will be charged a $35.00 fee

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY AND I AGREE TO BE BOUND BY ITS TERMS

Signature Patient/Legal Representative (*A parent/legal representative signature is required for patients under the age of 18 years)*

Date

Receipt of Notice of Privacy Policies & Consent

Patient Name _____

Patient Birthdate _____ Patient Phone Number _____

Patient Address _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices***.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for a restriction.

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Epic Vision Eye Centers on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown and authorizes my doctor to act as my agent as above.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Epic Vision Eye Centers.

_____ _____

Signature Patient/Legal Representative Date

If signing as a legal representative, describe the relationship to patient and source of authority.

_____ _____

Source of Authority/Relationship to Patient Print Name

Legal Representative Telephone _____

Legal Representative Address _____

Signature On File

- Signatures are required by patient/representative when Epic Vision Eye Centers will be billing the patient's insurances. Signatures are required in the following:
  - Medicare, Medicare replacement plans (Humana), Medicare secondary insurance – signature needed on all 3 sections
  - Commercial plans (BCBS, Cigna, EyeMed, VSP, etc.) – signature needed on line #3

1. MEDICARE

   I request that payment of authorized Medicare benefits be made on my behalf to Epic Vision Eye Center for services furnished to me by any Epic Vision Eye Centers Doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

   I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.

   Epic Vision Eye Center accepts the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

   Signature _____ Date _____

2. MEDIGAP

   If a Medigap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made either to me or on my behalf to Epic Vision Eye Center.

   Signature _____ Date _____

3. OTHER INSURANCE

   I hereby authorize payment of my medical and surgical insurance benefits to Epic Vision Eye Center. I understand I am financially responsible for any charges whether or not paid by said insurance. If copayments and/or deductibles are designated by my insurance company or health plan I agree to pay them to Epic Vision Eye Center. I authorize Epic Vision Eye Center to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

   Signature _____ Date _____