VISTA EYE SPECIALISTS ~ PATIENT MEDICAL HISTORY

Patient Name: _____ Birthdate: _____ Primary Care Doctor: _____

Please answer the following questions about your medical status and history. Check any conditions / symptoms you have had in the past or currently have.

MEDICAL HISTORY

- ☐ Diabetes Type _____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Cancer _____
- ☐ Auto-Immune Diseases
- ☐ Arthritis
- ☐ Thyroid
- ☐ Organ Transplant _____
- ☐ Other _____

OCULAR HISTORY

- ☐ Cataract
- ☐ Glaucoma
- ☐ Corneal Disease _____
- ☐ Previous Laser Vision Correction
- ☐ Other _____
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Strabismus / Eye Muscle Problems
- ☐ Do you have prism in your glasses? Y / N
- ☐ Trauma/Injury to Eye
- ☐ Contact Lens

Type: _____

Hours worn daily: _____

Are you interested in Laser Vision Correction? ☐ Yes ☐ No

LIST ANY SURGERIES DONE IN THE PAST: _____

_____

LIST ANY MEDICATIONS AND DOSAGES YOU ARE CURRENTLY TAKING: _____

_____

_____

LIST ANY DRUG OR FOOD ALLERGIES, INCLUDING REACTIONS: _____

_____

Do you take BLOOD THINNERS (i.e. Aspirin, coumadin)? ☐ Yes ☐ No

ARE YOU CURRENTLY TAKING OR HAVE YOU TAKEN ANY PROSTATE MEDS? ☐ Yes ☐ No

ARE YOU ALLERGIC TO LATEX? ☐ Yes ☐ No **HEIGHT:** _____**FT.**_____**IN.** **WEIGHT:** _____**LBS.**

PLEASE REVIEW AND MARK ANY PROBLEMS YOU MAY HAVE NOW, OR HAVE HAD IN THE PAST:

- ☐ Chronic Fever
- ☐ Anxiety
- ☐ Fatigue
- ☐ Weakness
- ☐ Sore Throat
- ☐ Sinus Problems
- ☐ Hearing Loss
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Coughing
- ☐ Abdominal Pain
- ☐ Heartburn
- ☐ Vomiting
- ☐ Urinary pain / discomfort
- ☐ Blood in urine
- ☐ Joint Pain
- ☐ Swollen Joints
- ☐ Muscle Aches
- ☐ Excessive Skin Dryness
- ☐ Skin Rashes
- ☐ Headaches
- ☐ Numbness
- ☐ Paralysis
- ☐ Abnormal Bleed / Bruise
- ☐ Unexpected weight gain / loss (circle one)
- ☐ Other: _____

FAMILY HISTORY

Medical / Eye Diseases in Family (check all that apply):

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Other _____

SOCIAL HISTORY

- ☐ Yes ☐ No Do you drive?
- ☐ Yes ☐ No Do you have trouble with night vision?
- ☐ Yes ☐ No Do you smoke? How much? _____ Former Smoker / Never Smoked
- ☐ Yes ☐ No Do you drink? How much? _____
- ☐ Yes ☐ No Women: Could you be pregnant?
- ☐ Yes ☐ No Have you had any falls or injuries since your last visit?

I have fully reviewed this questionnaire and answered all questions to the best of my knowledge. I am aware that my answers could affect my health care, or that patient for whom I am responsible.

Patient/Responsible Party Signature: _____ Date: _____

VISTA EYE SPECIALISTS- PATIENT INFORMATION

PATIENT INFORMATION:

FULL NAME: _____ DATE OF BIRTH: _____

ADDRESS, CITY, STATE & ZIP: _____

GENDER: _____ AGE: _____ SOCIAL SECURITY NUMBER (REQUIRED): _____

PHONE: HOME _____ CELL _____ WORK _____

OCCUPATION: _____ EMPLOYER: _____

MARITAL STATUS: S / M / W / D EMAIL: _____

Referred by? (Doctor/Friend/Patient/Website/Ad): _____

SPOUSE/DEPENDENT INFORMATION: (Parent/Guardian if patient is under 18 years old)

FULL NAME: _____ DATE OF BIRTH: _____

ADDRESS, CITY, STATE & ZIP: _____

GENDER: _____ AGE: _____ SOCIAL SECURITY NUMBER: _____

PHONE: HOME _____ CELL _____ WORK _____

OCCUPATION: _____ EMPLOYER: _____

EMERGENCY CONTACT:

FULL NAME: _____ RELATIONSHIP: _____

ADDRESS, CITY, STATE & ZIP: _____

PHONE: HOME _____ CELL _____ WORK _____

MEDICAL AUTHORIZATION: Name of Family Member to Release Health Information _____

PREFERRED CONTACT METHODS:

May we send mail to your home address? YES / NO (**If not** please provide an alternate address): _____

_____

With the phone numbers you provided in the patient information section listed above which is the preferred contact method we will be able to reach you at regarding your care and leave voicemails? (Circle all that apply)

HOME: YES / NO CELL: YES / NO WORK: YES / NO

Other than you, your insurance company, and all health care providers involved in your care, whom may we speak with about your health care information? (Child/Spouse/Caretaker/Parent/Etc.)

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Do you have any health information that you would like to be kept confidental from any person or persons? If so, please specifically describe the information and the person or persons below : _____

_____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information. I acknowledge that I have been given the opportunity to request means of communication of my protected health information.

HIPAA DISCLOSURE & INSURANCE AUTHORIZATION / ASSIGNMENT AGREEMENT: I hereby authorize this office disclosure of my health information and/or apply to apply for benefit for covered services rendered. I request payment from my insurance company to be made in the above named provider. I certify that the information I have with regard to my insurance coverage is correct and further authorize the release of any necessary information medical information, to other treating physicians and to my insurance company in order to determine insurance benefits to which I may be entitled. Either myself or my insurance company at any time may revoke this authorization in writing. By signing below, I acknowledge that I have read or understand this authorization.

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____ **DATE:** _____

VISTA EYE SPECIALISTS

POLICIES & AUTHORIZATIONS

REFRACTION POLICY

A refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contact lenses. Most medical insurance plans, including Medicare, ***DO NOT COVER*** routine refractions or routine eye exams. Medicare allows that we charge separately for that portion of the examination, since it is not a covered service. Our office **fee** for refraction is **$ 45** and this fee is collected at the time of service in addition to any co-payment your insurance plan may require.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that Vista Eye Specialists may use and disclose my protected health information for purposes of treatment, payment, and health care operations. I also acknowledge that I have received, have been offered, or have received in the past a copy of the Practice's Notice of Privacy Practices, which provides information about how the Practice, and individuals involved in my care in the Practice, may use and disclose my protected health information. As provided in the Notice, the terms of the Notice may change. To obtain a current copy of any current Notice, I understand that I can contact the Privacy Officer at (888) 393-5264.

I understand that I have the right to request that the Practice restrict how my protected health information is used or disclosed for treatment, payment or health care operations, but I also understand that the Practice is not required to agree to a requested restriction. However, if the Practice does agree, it is bound by the agreement. I understand that I have the right to revoke this consent in writing at any time, except to the extent that the Practice, or individuals involved in my care in the Practice, have already used or disclosed protected health information in reliance on my prior consent.

Some insurance companies and labs require a social security number to verify coverage and obtain test results. As with your other medical information we handle this sensitive information with the utmost care to protect your privacy in compliance with Health Insurance Portability and Accountability Act (HIPAA). Without a social security number we must require payment in full at time of service and we will furnish documentation for you to file for insurance reimbursement.

PAYMENT INFORMATION

All payments including ***Co-pays and Deductibles are due at the time of service***. Co-pays that are not paid at the time of service will be billed with an additional **$10** fee. If the account has to be turned over to an attorney/collection agency, the undersigned agrees to pay all cost of collections, including attorney fees (33 1/3%), interest, commission, and court costs, whether suit is filed or not. This form will be placed in your chart and be applicable until such information is changed. There is a **$50** fee for any check returned by your bank. A **$10** surcharge on top of any balance that is due to Vista Eye Specialist will be assessed each and every month after the first bill is received by the patient *if not paid within 30 days* of receipt of said bill. Each and every month that the original balance is still outstanding an additional $10 per month will continue to accumulate until all balances are paid.

MEDICARE LIFETIME SIGNATURE ON FILE:

I request that payment of authorized Medicare benefits be made on my behalf to Vista Eye Specialists for any services furnished me by the physician. 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.

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS/INFORMATION RELEASE:

I, the undersigned, authorize payment of medical benefits to Vista Eye Specialists for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administrating claims of benefits.

NO SHOW / MISSED APPOINTMENTS / CANCELED SURGERY

I understand that I will be charged **$50** for a no show or missed appointment where a 48 hour notice is not provided to Vista Eye Specialists. I understand that I will be charged **$250** for missed or canceled surgery if a two week notice is not provided other than for a medical reason.

REFERRALS

I understand that it is my responsibility to obtain a referral if it is required by my insurance company. ***I will be responsible for all charges if I am seen without a referral***.

By signing below, I acknowledge that I have read and understand these policies and authorizations.

Patient/Responsible Party Signature: _____ **Date:** _____