

Tech Initials _____

CEDAR PARK EYE CARE

Exam Date _____/_____/_____

PATIENT REGISTRATION AND INSURANCE INFORMATION

Name: _____ Sex: _____ D.O.B.: ____/____/____
 Address: _____ Pt SS#: ____-____-____ D.L. _____
 City/St/Zip _____ Home Tel #: _____
 Occupation/Employer: _____ Work Tel #: _____
 E-Mail: _____ Alternate # _____

Primary Insurance Information (Medical Insurance)

Insured Member: _____ Relationship _____ D.O.B. ____/____/____
 S.S. #: ____-____-____ Policy #: _____ Employer: _____
 Address: _____ Insurance Plan: _____
 City/St/Zip _____ Group # _____
 Id # _____ **Authorization #** _____
 Patient Status: Single Married Other Employed Student (F-T) Student (P-T)

Other Insurance (Supplemental (VSP, EyeMed, Superior, etc)):

Insurer's Name: _____ Relationship _____ D.O.B. ____/____/____
 Phone#: _____ Policy#: _____
 Address: _____ Group # _____

I authorize payment of my medical benefits to the undersigned physician / supplier for services rendered. I understand that Cedar Park Eye Care will make every effort possible to bill my insurance company and obtain all the necessary information for proper billing in advance of the services. I also understand that if Cedar Park Eye Care is unable to obtain authorization from my insurance company or if my insurance company fails to cover the services and materials, **I will be personally responsible for the benefits rendered.** I am responsible for all accounting fees in the event of my non-payment.

I understand that my medical records are confidential and that by signing this consent form I am allowing my information to be released to my insurance company upon request. I understand that I can restrict specific information in my records if I request such restrictions in writing and that such restrictions may affect my insurance coverage.

Signed: _____

I acknowledge that I have reviewed a copy of Dr. McCarty's notice of Privacy Practices regarding HIPAA policies. I also understand that I am entitled to a copy of this notice upon request.

Signed: _____

DILATION AND ADDITIONAL TESTS

The dilated eye examination allows a more thorough evaluation of the internal health of the eyes. The Optomap examination is a new digital imaging system that allows our doctors to view the inside of your eyes without dilation. If you have the Optomap retinal exam performed, dilation may not be necessary. Your doctor will determine the necessity to dilate. Dilation will result in increased light sensitivity and possibly blurred vision at reading distance (usually lasting around three hours).

Please indicate if you wish to accept or decline this test,

- I prefer to have the Optomap exam. I understand that the fee is \$34.**
- I agree to dilation as determined by my doctor**
- I decline dilation, understanding that my decision may decrease my doctors ability to thoroughly evaluate the health of my eyes.**

Please check the box below if you would like to have a visual field screening. This test is an **additional \$15** but is very helpful in detecting visual defects that may occur such as Glaucoma, Diabetes and/or Macular Degeneration.

- I agree to the visual field test.**
- I do not want this test performed.**

MEDICAL HISTORY

Date ____/____/____

What is the reason for today's visit? _____
When was your last Eye exam? _____ Name of Eye Doctor _____ City _____
When was your last Medical exam? _____ Name of Doctor _____ City _____
Do you wear glasses? Yes No How old is your current pair of lenses? _____
Do you wear contact lenses? Yes No How old is your current pair of contact lenses? _____
What type? Rigid Soft Disposable (how often replace?) _____ Are they comfortable? Yes No
If not currently wearing contacts, are you interested in contact lenses? Yes No Bifocal Contacts? Yes No
Are you interested in information regarding Laser Vision Correction? Yes No

Please note any history for the following conditions (self, parents, grandparents, siblings, children, etc.)

CONDITION	RELATIONSHIP	CONDITION	RELATIONSHIP
Blindness	_____	Arthritis	_____
Cataract	_____	Cancer	_____
Crossed Eyes	_____	Diabetes	_____
Glaucoma	_____	Heart Disease	_____
Macular Degeneration	_____	High Blood Pressure	_____
Retinal Detachment	_____	Thyroid Disease	_____
Retinal Disease	_____	Lazy Eye	_____

Do you have any allergies to medications? Yes No If so, please list _____

List any over-the-counter or prescription medications you take on a regular basis _____

Do you have difficulty driving? Yes No Please briefly explain _____

Do you use tobacco products? Yes No Type/Amount/How long: _____

Do you drink alcohol? Yes No Type/Amount/How long: _____

Do you use illegal drugs? Yes No Type/Amount/How long: _____

Have you ever been exposed/infected with: Gonorrhea Hepatitis HIV Syphilis Herpes

REVIEW OF SYSTEMS

Do you have or are you currently being treated for any problems in the following areas:

CONSTITUTIONAL

Fever, Weight Loss/Gain Yes No

INTEGUMENTARY

Skin Yes No

NEUROLOGICAL

Headaches Yes No

Migraines Yes No

EYES

Loss of Vision Yes No

Blurred Vision Yes No

Distorted Vision/Halos Yes No

Loss of Side Vision Yes No

Double Vision Yes No

Dryness Yes No

Mucous Discharge Yes No

Redness Yes No

Sandy or Gritty Feeling Yes No

Itching Yes No

Burning Yes No

Foreign Body Sensation Yes No

Excess Tearing/Watering Yes No

Glare/Light Sensitivity Yes No

Eye Pain or Soreness Yes No

Stye or Chalazion Yes No

Flashes of Light/Floaters Yes No

Tired Eyes Yes No

ENDOCRINE

Thyroid/Other Yes No

EARS, NOSE, MOUTH, THROAT

Seasonal Allergies Yes No

Sinus Congestion Yes No

Post Nasal Drip Yes No

Chronic Cough Yes No

Dry Mouth Yes No

RESPIRATORY

Asthma Yes No

Chronic Bronchitis Yes No

Emphysema Yes No

CARDIOVASCULAR

Diabetes Yes No

Heart Palpitations Yes No

High Blood Pressure Yes No

Vascular Disease Yes No

GASTROINTESTINAL

Diarrhea Yes No

Constipation Yes No

GENITOURINARY

Genitals / Kidney / Bladder Yes No

MUSCULOSKELETAL

Rheumatoid Arthritis Yes No

Muscle Pain Yes No

Joint Pain Yes No

LYMPHATIC / HEMATOLOGIC

Anemia Yes No

Bleeding problems Yes No

PSYCHIATRIC

Yes No

If you answered YES to any condition above or have a condition not listed, please explain: _____

CEDAR PARK EYE CARE FINANCIAL POLICY

The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment. Full payment for service(s) is due at the time of service(s). We accept cash, checks, Visa, MasterCard, American Express and Discover. *We also offer Care Credit as our extended payment option. Ask our staff for details.*

Traditional Insurance As a courtesy, we will be happy to file your insurance claim and accept assignment of insurance benefits. Our staff will be happy to assist you in determining your insurance coverage. **However, benefits quoted by your insurance company are not a guarantee of payment.** Therefore, we must have a valid credit or debit card number and expiration date on file in case of non-payment by your insurance company. Non-payment by your insurance company may be due to insurance deductibles that have not been met or for services not covered. You should receive an Explanation of Benefits (EOB) from your insurance company when a claim is filed. In cases where your claim is denied or partially paid by your insurance company, your credit or debit card will be charged for unpaid allowable amounts. A receipt will be mailed to you along with an additional copy of the EOB. Our office is not a party to any dispute of non-payment between you and your insurance company. Your insurance policy is an agreement between you and your insurance company.

PPO Regarding insurance plans, it is your responsibility to be sure we are a participating (in network) provider on your vision plan or your medical insurance plan. All co-pays and deductibles are due at time of service.

Usual and Customary Fees Our practice is committed to providing the best treatment for our patients. You are responsible for payment regardless of your insurance company's determination of usual and customary rates.

Minor Patients A legal guardian must accompany minors at their initial visit and by an adult at all subsequent visits. The legal guardian is responsible for full payment of services at the time of treatment. Should the recommended plan of treatment change, approval is required by the legal guardian. If the legal guardian is not present at subsequent visits, he or she must be available by phone in the event of an emergency to approve any changes in treatment, or for any reason that may arise. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized. The legal guardian is required to notify our office of any changes in the minor's medical history prior to treatment.

Divorce Decrees This office is NOT a party to your divorce decree. The legal guardian who accompanies the minor at the initial visit is responsible for payment.

If you would like our office to file a claim with your insurance company for you, please be prepared to provide a credit card as a secondary form of payment in case your claim is denied or you have not met your deductible.

I have read the Financial Policy. I understand and agree to this Financial Policy. I agree to allow Cedar Park Eye Care to charge my credit card or debit card in the event that all or a portion of my insurance claim is denied for services rendered or materials dispensed and/or in the event that my check is returned for insufficient funds. I understand that an additional fee of \$25.00 will be charged for all returned checks.

X

(Patient or Guardian if patient is a minor)

Date

I have reviewed all the information on this form including address, insurance information, email address and have determined it to be accurate and complete.

X

Patient or Guardian if patient is a minor

Date

2nd Update- Patient or Guardian

Date

3rd Update - Patient or Guardian

Date

4th Update - Patient or Guardian

Date