COMPLETE FAMILY EYECARE

Patient Information Form

Patient Information :

First name:_____ **Last name:**_____ **Middle Int.:**_____

Nickname:_____ **Birth Date:**_____/_____/_____ **SSN#:**_____-_____-_____

Address:_____ **City:**_____ **State:**_____ **Zip Code:**_____

Phone #:_____ **Email:**_____ **Gender at Birth:** ☐ Male ☐ Female

Race *(CHECK ☑ one)*:

☐ American Indian/ Alaska Native ☐ Asian ☐ African American ☐ Native Hawiian or other Pacific Islander ☐ White ☐ Other

Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Other

Employer/School:_____ **Occupation/Grade:**_____

☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Retired

Primary Care Physician :

Doctor:_____ Office:_____ Phone #:_____

Pharmacy :

Name:_____ Location:_____ Phone #:_____

Emergency Contact *(if other than guardian)* :

Name:_____ Relationship:_____ Phone #:_____

Parent/Guardian Information : * *if applicable*

Name 1:_____ **Relationship:**_____

Cell #:_____ **Work #:**_____ **Email:**_____

Name 2:_____ **Relationship:**_____

Cell #:_____ **Work #:**_____ **Email:**_____

Primary MEDICAL Insurance :

Insurance:_____ **Plan:**_____

Policy Holder Name:_____ **Policy #:**_____

Birth Date:_____/_____/_____ **SSN#:**_____-_____-_____ **Relationship:**_____

Primary VISION Insurance : *insurance card must be provided

Insurance:_____ **Plan:**_____

Policy Holder Name:_____ **Policy #:**_____

Birth Date:_____/_____/_____ **SSN#:**_____-_____-_____ **Relationship:**_____

A current insurance card and updated information is REQUIRED at each visit. If I do not provide Complete Family Eyecare with accurate insurance information and current insurance cards at the time of service, I will be responsible to pay for rendered service until information is updated. If a service is denied due to deductible, co-insurance, co-payment, or service is considered non-covered, I accept total responsibility for any charges, attorney fees, and/or collection agency fees incurred in the process of recouping my payment. Co-payment is due at the time of service. Materials being ordered must be paid in full prior to order being placed. **I have read, understand, and agree with the above information:**

Signature:_____ **Date:** _____

LEFT BLANK INTENTIONALLY

Patient Health Information Form

Patient name:_____ **Birth Date:**_____/_____/_____

Form completed by:_____ **Relationship:**_____

Eye Conditions :

CHECK ☑ any eye conditions listed the **PATIENT has had in the past or currently has*

- ☐ **cataract**
- ☐ **glaucoma**
- ☐ **diabetes**
- ☐ **diabetic retinopathy**
- ☐ **dry eye**
- ☐ **eye infection, inflammation, or allergy**
- ☐ **floaters and or/ flashes of light**
- ☐ **iritis/uveitis**
- ☐ **retina defects or degenerations**

Eye Concerns :

**CHECK ☑ all that apply*

- ☐ **redness**
- ☐ **burning**
- ☐ **itching**
- ☐ **discharge**

Vision Concerns : Has the patient had: **CHECK ☑ all that apply*

- ☐ **blurred vision**
- ☐ **eyestrain**
- ☐ **eye pain**
- ☐ **severe sensitivity to light**
- ☐ **headache**
- ☐ **poor night vision**
- ☐ **bothersome night glare**
- ☐ **double vision**
- ☐ **total loss of vision**

Vision Correction : **circle applicable answer, elaborate if YES*

Has the patient ever been prescribed corrective lenses? **YES NO** **What age?** _____

Does the patient currently wear corrective lenses? **YES NO** **When?** _____

If the patient has/had corrective lenses what are they for? _____

Does the patient currently wear contact lenses? **YES NO** **What brand?** _____

Is the patient interested in contact lenses? **YES NO** **Wore before? YES NO**

Computer Demands : **CHECK ☑ applicable answer*

Amount of hours a day using the computer?

☐ **Less than 3 hours** ☐ **3-6 hours** ☐ **6-9 hours** ☐ **9+ hours** ☐ **never**

Medical History : **CHECK ☑ all that apply*

Const.
- ☐ **development disabilities**
- ☐ **cancer**
- ☐ **fatigue syndrome**

Neuro.
- ☐ **multiple sclerosis**
- ☐ **epilepsy**
- ☐ **cerebral palsy**
- ☐ **tumor**
- ☐ **stroke/CVA**
- ☐ **migraine**
- ☐ **autism spectrum disorder**

GU
- ☐ **kidney disease**
- ☐ **prostate disease/cancer**
- ☐ **STD-herpetic/chlamydia**
- ☐ **Benign Prostate Hypertrophy**
- ☐ **pregnant**
- ☐ **nursing**
- ☐ **Herpes**

Integ.
- ☐ **eczema**
- ☐ **rosacea**
- ☐ **psoriasis**
- ☐ **Herpes Simplex/Cold Sores**
- ☐ **Herpes Zoster/Shingles**

Allergy/Immun.
- ☐ **drug allergies**
- ☐ **environmental allergies**
- ☐ **rheumatoid arthritis**
- ☐ **Lupus**
- ☐ **Sjogren's Syndrome**

Musc./Skel.
- ☐ **arthritis**
- ☐ **osteoarthritis**
- ☐ **fibromyalgia**
- ☐ **muscular dystrophy**
- ☐ **Ankylosing Spondylitis**
- ☐ **osteoporosis**
- ☐ **gout**

Cardio
- ☐ **hypertension**
- ☐ **heart disease**
- ☐ **vascular disease**
- ☐ **congestive heart failure**

Endo.
- ☐ **Type 1 Diabetes mellitus**
- ☐ **Type 2 Diabetes mellitus**
- ☐ **thyroid dysfunction**
- ☐ **hormonal dysfunction**

Psych.
- ☐ **depression**
- ☐ **attention deficit**
- ☐ **anxiety disorder**
- ☐ **bipolar disorder**

Hem./Lymph.
- ☐ **anemia**
- ☐ **large volume blood-loss**
- ☐ **hypercholesterolemia**

ENT
- ☐ **hearing loss**
- ☐ **sinusitis**
- ☐ **dry mouth**
- ☐ **laryngitis**

Resp.
- ☐ **asthma**
- ☐ **bronchitis**
- ☐ **emphysema**
- ☐ **chronic obstruction**
- ☐ **sleep apnea**

GI
- ☐ **Crohn's**
- ☐ **colitis**
- ☐ **ulcer**
- ☐ **acid reflux**
- ☐ **celiac disease**

Other : _____

_____

Medications : **List all current medications and vitamins or give a copy of medications list*

Name:_____ Dosage:_____ Name:_____ Dosage:_____

Name:_____ Dosage:_____ Name:_____ Dosage:_____

Name:_____ Dosage:_____ Name:_____ Dosage:_____

Name:_____ Dosage:_____ Name:_____ Dosage:_____

Name:_____ Dosage:_____ Name:_____ Dosage:_____

Name:_____ Dosage:_____ Name:_____ Dosage:_____

Name:_____ Dosage:_____ Name:_____ Dosage:_____

Allergies :

List any known PRESCRIPTION DRUG allergies:_____

_____

List any OTHER allergies: _____

_____

Latex Sensitivity? **CHECK ☑* ☐ **YES** ☐ **NO**

Ocular History : **CHECK ☑ all that apply*

☐ **eye surgery** ☐ **strabismus** ☐ **retinal detachment** ☐ **keratoconus**
☐ **patching** ☐ **retinal hole** ☐ **eye injury** ☐ **nystagmus**
☐ **Other**_____

Family History : **circle applicable answer, elaborate if YES*

Does the patient drink alcohol? **YES** **NO** **Amount?** _____

Does the patient smoke? **YES** **NO** **Amount?** _____packs per day

Does the patient use chewing tobacco? **YES** **NO** **Amount?** _____

Family History : **CHECK ☑ all that apply*

	Father	Mother	Brother	Sister	Son	Daughter
Hypertension	☐	☐	☐	☐	☐	☐
Diabetes Mellitus Type 1	☐	☐	☐	☐	☐	☐
Diabetes Mellitus Type 2	☐	☐	☐	☐	☐	☐
Hyperthyroidism	☐	☐	☐	☐	☐	☐
Hypothyroidism	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	☐	☐
Cataract	☐	☐	☐	☐	☐	☐
Strabismus/Lazy Eye	☐	☐	☐	☐	☐	☐

(OFFICE POLICIES, continued)

PRESCRIPTION POLICY:

Eyeglass lenses and frames may NOT be returned or exchanged after purchase. All lenses are made specifically for your vision needs and specifications. We will make any necessary adjustments to ensure proper fit and best vision possible. Cancellation of material orders will have a restocking fee.

If you choose to have your eyeglasses made outside of this office, we will NOT take any responsibility for the accuracy or quality of your eyeglasses. If you choose to have your eyeglasses made outside of this office, we recommend you reach an agreement with your eyeglasses dispenser before you place your order.

Contact lenses may only be returned for credit or exchange, no refunds will be given. They must be intact, in their original packaging with no markings, non-expired, and returned within 30 days of receipt. Custom orders cannot be returned for credit. Fitting and assessment fees are non-refundable. Medical insurances do not cover the assessment for contact lenses. Wellness vision benefits such as VSP do not cover the fitting as part of their basic exam.

We do not take any responsibility for contact lenses purchased outside this office. If the prescription changes or the physical fit of the contact lenses change, you will be responsible for the cost of any new contact lenses.

I have read and agree to the above policies and conditions. Unless revoked by me in writing, this authorization will remain in effect for the lifetime of my relationship with Complete Family Eyecare.

Patient Name : _____

_____	_____	_____
Signature of Patient or Guardian	*Printed Name*	*Date*

Patient Portal

Complete Family Eyecare is happy to offer our patients access to our patient portal. In our patient portal you will be able to:

- Update demographics and contact information
- View receipts and account balances
- Access record summaries including prescriptions

☐ **I agree to have Patient Portal access to the above information.**

☐ **I decline access to the Patient Portal and understand that the information available to me on the portal will be provided to me upon request.**

☐ **I have access to my Patient Portal and do not need to update.**

One of the options above **MUST BE CHECKED ☑ and a signature below of the decision **MUST BE** provided.*

_____	_____	_____
Signature of Patient or Guardian	*Printed Name*	*Date*

LOGIN at www.revolutionphr.com

Email address:_____

OFFICE POLICIES

FEES:
Complete Family Eyecare (CFE) is committed to providing the best treatment to our patients. Our fees are representative of the usual and customary charges for the level of service provided, materials prescribed, as well as the level of advanced technology used to provide our patients with the most up to date eyecare.

CONSENT TO TREAT:
I request and give consent to CFE to provide and perform such medical and vision eye care, tests, procedures, medications and other services and supplies as are beneficial for my eye health, wellbeing, and vision.

An Optomap Retinal Exam will be performed as one of the required tests at your exam. The Optomap provides an eye wellness scan, gives an in-depth view of the retinal layers, provides an annual, permanent record for the medical file, is fast, easy, and comfortable and does NOT require dilation drops, which can result in blurred vision, and sensitivity to light for 4-6 hours.

This test can help see early signs of any ocular conditions and systemic diseases such as:
- Detection of macular degeneration, retinal detachment or holes, diabetic retinopathy, glaucoma, and hypertension (high blood pressure.)
- Life-threatening diseases such as cancer, stroke, or cardiovascular disease.
- Early protection from vision impairment or blindness.

PAYMENT:
You are responsible for any co-pays, co-insurance, deductible, and other non-covered services such as contact lens assessment and refraction at the time of service. If you are being seen for any ongoing medical condition, co-pays are due at each visit. If you are a self-pay patient and/or your insurance cannot be verified prior to your appointment, you will be required to pay in full the day services are rendered. All material orders must be paid for at the time of service before any orders are processed. Patients who receive a statement from our office are expected to remit full payment upon receipt. Statements will not be sent for any balance under $5.00. You may have a small balance on your account at the time of your next visit or order.

If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. If your account must be referred to an outside collection agency for non-payment, a fee will be added to your account to cover the expense incurred from the agency. Patients in collections will be seen on an emergency only basis and must make payment in full prior to scheduling another appointment with our office.

Checks returned from your financial institution will be charged back to you with an additional $30.00 fee.

We offer 6 and 12 month payment plans through Care Credit.
- You may apply for Care Credit at www.carecredit.com.

INSURANCE CLAIM FILING:
As a courtesy to our patients, we will file claims with insurance companies for which we are providers. We will do our best to verify benefits for services and/or materials; however, benefits quoted by your insurance carrier are not a guarantee of payment. You are responsible for supplying complete, accurate and up to date insurance information. Should your insurance deny a claim for any reason, you will be responsible for any remaining balances as directed by your insurance.

I would like CFE to file claims to my insurance on my behalf. My signature below authorizes CFE to act as my agent to bill for insurance and/or Medicare benefits, and I authorize payment of these benefits to be paid directly to CFE on my behalf. I authorize CFE to release any medical information needed to determine those payable benefits.

If CFE does not file claims to my insurance, I will be responsible for the total cost of all services provided.

PATIENT AUDIO & VIDEO RECORDING POLICY:
To protect the privacy, safety, and confidentiality of all patients, providers, and staff, audio and video recording of any kind is prohibited within any area of the office. This includes recording through cell phones, smart watches, tablets, cameras, wearable technology or any other device. Failure to comply with this policy may result in dismissal from the practice after recordings have been deleted.

(office policies continued & signatures of patient REQUIRED on next page)

HIPAA

As required by the Health Insurance Portability and Accountability Act, Complete Family Eyecare may not use or disclose your health information without your authorization.

(Printed name of PATIENT)

I, _____, understand that this authorization is voluntary. I understand that my health information may be protected by the Federal rules for Privacy of Individually Identifiable Health Information and/or state laws. I understand my health information may be subject to re-disclosure for the purpose of billing insurance, referrals, prescriptions, and legal processes and if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the federal privacy regulations.

I understand it is the policy of Complete Family Eyecare that all my appointments may be confirmed by phone or text prior to my office visit. If no one is home, a message will be left on my answering machine/voicemail with the time and date of my scheduled appointment. I understand this confirmation process cannot be waived or declined by myself or any individual.

I authorize Complete Family Eyecare may give information regarding my appointments and my healthcare information to the following person(s):

Name 1:_____ Relationship:_____ Phone #:_____

Name 2:_____ Relationship :_____ Phone #:_____

Name 3:_____ Relationship:_____ Phone #:_____

I understand that health records may contain information regarding mental health, substance use or dependency, sexuality, and may contain confidential HIV/AIDS related information. I further understand that by signing below, I am authorizing the release or exchange of information/records for the purpose of billing to insurance for benefit management and claims administration, prescriptions, legal processes and subpoenas, mandated treatment referral, and/or the release of physical records as requested by myself or my legal representative.

I understand I do not have to sign this authorization form. I understand I may inspect or copy the protected health information to be disclosed by Complete Family Eyecare. I also understand, if, by my refusal to sign, I am preventing the billing of insurance for payment of charges, all non-emergent treatment may be refused.

Except to the extent when action has already been taken in confidence on this authorization, I may, at any time, revoke this authorization by submitting a written notice to the office of Complete Family Eyecare at any of the addresses listed below. Unless revoked, this authorization will not expire.

My signature below indicates I have been given an opportunity to ask any questions and have them answered before signing.

I authorized Complete Family Eyecare to release the protected health information as above.

_____ _____ _____

Signature of Patient / Parent or Guardian *Printed Name* *Date*