EXECUTIVE EYE ASSOCIATES

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EXECUTIVE EYE ASSOCIATES - EXAMINATION AND TREATMENT OF THE EYE

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Today's Date _____

Title ____ Last Name _____ First Name _____

Home Address:

Street _____ City _____ Zip _____

Birthdate (MM/DD/YYYY) _____

SSN#, last 4 digits (used for insurance verification only _____

Contact Information:

(Please mark preferred method of contact):

□Cell_____ □Home_____ □Work_____

Email _____

Employer/School/Occupation _____

Name of Parent or Legal Guardian if under 18 years old _____

Date of last eye exam: _____

Are you currently having eye or vision problems? □Yes □No

If yes, please explain _____

Do you wear glasses? □Yes □No If yes, how old are they? _____

Are they progressives? □Yes □No **Are your glasses?** □Reading □Distance □Both

Do you wear contact lenses? □Yes □No

Medical History/Review of Systems:

List any medications you are now taking including eye drops, birth control pills, vitamins, prescribed medications, or over the counter medications (you may provide a list to us if you have one):

_____

Are you allergic to any medications?

If yes, please list _____

Primary Care Physician/Pediatrician _____

Preferred Pharmacy: Location_____ Phone _____

Do you have any of the following conditions?

Asthma/COPD _____ Diabetes _____ Heart Conditions _____ Urinary _____

Hypertension _____Elevated Cholesterol _____ Thyroid _____ GI issues _____

Arthritis _____ Musculoskeletal _____ Endocrine _____ Neurological _____

Respiratory _____ Ear/Nose/Throat _____ Skin _____ Psychiatric _____

Autoimmune _____ Cancer _____ Other _____

Are you currently pregnant or nursing? _____

List any major injuries/surgeries/hospitalizations: _____

Do you have or have you ever had any of the following? (check all that apply)

Blurred vision _____ Retinal Detachment/Tear_____ Flashes/Floaters _____

Dry Eye (Burning/Tearing) _____ Glaucoma _____ Macular Degeneration _____

Cataracts _____ Eye Injury _____ Lazy Eye/Amblyopia _____ Other _____

Family History (Mother, Father, Grandparents, Siblings):

Do you have any family history of eye disease?

If yes, please explain: _____

INSURANCE INFORMATION (MUST FILL OUT)

Primary Vision Insurance if Applicable:

Name of Insurance _____

Subscriber Name _____

Subscriber DOB _____

Subscriber SSN (last 4 digits) _____

Primary Medical Insurance:

Name of Insurance _____

Subscriber Name _____

Subscriber DOB _____

Member ID _____

Signature of legal guardian or parent if under 18_____

Signature_____ Date_____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have been informed of the HIPAA policy at Executive Eye Associates.

(A copy is available on display in the waiting room. Please ask for a copy if you would like)

Notice of Privacy Practice Date _____

Patient Name _____

Signature _____

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Payment for Services, Financial Responsibility & General Policies

- Patients are responsible to know their own insurance information
- Executive Eye Associates will submit a claim to the insurance that is provided by the patient at the time of visit. Should I present with incorrect insurance information at the time of services, I understand that Executive Eye Associates will not be responsible for submitting additional claims and that I will accept financial responsibility.
- Executive Eye Associates will not resubmit a claim if a patient gives us another insurance after their visit.
- **ALL PAYMENTS ARE FINAL**. Both glasses and contact lenses are custom ordered to the patient and may not be returned once payment is made.
- Any payment that is not covered by insurance, copayments, deductibles, refraction fees, non-covered services are my responsibility and due in full.
- Should I be a Medicare beneficiary, I understand that the refraction (the part of the eye exam that determines eyeglass prescription) is a non-covered service.
- Vision insurance will only cover a routine eye exam. It will NOT cover any visit that is medical based. If the provider deems a medical visit is necessary, the patient's medical visit may be billed. Specialist copays will apply.
- Contact lens services are generally not covered by insurance.
- I agree to pay an additional collection fee for all accounts not paid.
- Once an account is sent to collections, all payments must be made directly to the collection's agency. At that point, we are unable to remove any fees from your account.
- I authorize the release of medical information concerning my illness and treatment to my insurance company. I also authorize the release of my personal medical information to any doctor whom I may be referred to.
- I understand verification of eligibility is not a guarantee of payment.
- No request for record release will be honored without the written signed consent by the patient or appropriate guardian of patient. There is a $1 copy fee for every page copied and released. There is a postage fee determined by weight and means of delivery.
- Appointment cancellations must be made at least 24 hours in advance and failure to do so will result in a financial fee of $50. No-shows will result in a financial fee of $50.
- Should your insurance require a referral, it is the responsibility of the patient to know. Referrals must be present at the time of visit. Any payment due for failure to provide a referral is the responsibility of the patient.
- I authorize payment of my insurance benefits to Executive Eye Associates.

Signature of Patient or Legal Guardian _____

Date_____

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OPTOMAP RETINAL IMAGING

Optomap retinal imaging allows our office to offer the latest technology for a more comprehensive way of viewing the inside of your eyes, your retina, by just the click of a camera. It is a quick, easy and painless procedure. Eye drops are not necessary to perform this test and there is no down time afterwards. This test is invaluable in detecting peripheral defects of the eyes and monitoring eye diseases, such as glaucoma, diabetic retinopathy or macular degeneration, and detecting diseases of the body including diabetes, high blood pressure, and high cholesterol. It also allows us to check your arteries and your veins, any signs of pigmentation, cancers of the eye or in some cases systemic, and defects in the vitreous such as floaters.

Optomap is highly recommended **annually for all patients** especially those with a family history of the above diseases, is very nearsighted, has a history of trauma, new patients to our office and/or has never had a complete eye exam. The fee for this procedure is $29 and may be covered by insurance if one of the above conditions is present. Your doctor will go over the image with you in depth and let you know if it will be covered at that time. If you have any questions, the doctor will be happy to discuss this in more detail.

I APPROVE OF AN EXTRA $29 FEE FOR THIS PROCEDURE _____ (Sign & Date)

CURRENT AND FUTURE CONTACT LENS WEARERS

Executive Eye Associates prescribes high quality contact lenses to improve your vision and lifestyle. Contact lenses are FDA regulated medical devices that can cause discomfort, infections, and even permanent vision loss if not fitted and cared for properly. New and existing contact lens wearers require additional time and testing during an eye examination to minimize the risk of serious eye problems. This additional testing is only done for contact lens wearers, not for patients who do not wear contact lenses. Even if there is no change in fitting or prescription, an evaluation of the contact lenses and eye health must be done annually. For this reason, there are additional contact lens evaluation and service fees for new and existing contact lens wearers. Your contact lens evaluation and service fee (also called a fitting fee) include the following:

1) Evaluation of current and new lenses to ensure optimal fit, vision and comfort.
2) Medical assessment of the cornea, tear film layer, & conjunctiva.
3) Instruction regarding safe contact lens wear, proper care and disinfecting.
4) Any trial lenses and follow up appointments that may be necessary.

All patients who wish to order contact lens within the year must have a contact lens evaluation in order to do so. Please wear your current contact lenses in to your appointment as well as your case & glasses. Bring your boxes or prescription if the contact lens prescription is not from our office. Some insurance plans cover a portion of your contact lens fees. If eligible, this will be applied after your visit.

Signature _____Date _____