

As a new patient to our practice, we would like to offer a warm welcome and our thanks for choosing us to provide your eye health and vision care. In order for us to establish your file and provide the most beneficial use of your time with us, the doctor has asked you to complete the following items and bring them with you to your appointment.

- Photo Identification**
- Completed Patient Information Form:** This information includes personal demographics needed to establish your file and billing/insurance indicating who will be financially responsible for your visit.
- Completed Medical and Eye Health History:** Since many general health conditions may be associated with visual symptoms and/or eye health problems, this important record will allow us to care for you as a "whole person" rather than just a pair of eyes. This form includes a complete list of prescription and non-prescription medication.
- Completed Agreement of Responsibility:** This form details the understanding that the patient is ultimately responsible for all charges incurred, allows Moyes Eye Center to bill your insurance, and gives Moyes Eye Center consent to treat.
- Completed HIPAA Patient Notice:** This form describes how Moyes Eye Center will use your medical information.
- Insurance cards or claim forms:** For all medical insurance you have coverage with.
- Eyeglasses:** Please bring ALL pairs of eyeglasses you currently use, including prescription or non-prescription reading glasses, sunglasses, etc. We have instruments to compare the optical power of your old lenses with your new exam findings, thus enabling us to determine and explain how your vision has changed over time. We can also evaluate the condition and fit of your current eyewear.
- Medications, eye drops, ointments, etc:** Please bring ALL medications, eye drops or ointments that you currently use in a small bag and bring it along with you. These are necessary to complete your chart and your doctor will review these during the examination.
- Dilation Explained:** The doctor may use drops to dilate your eyes in order to fully evaluate their internal health. This has the effect of temporarily increasing sensitivity to light and causing "fuzzy" vision at near (reading) distance for a period of up to 2-3 hours. Please make the necessary arrangements so that you are prepared to have your eyes dilated during the exam.
- Time Expectations:** A complete dilated eye exam will take 1 to 2 hours to complete from start to finish. This time may be less or more depending on the circumstances of your eye health. If your appointment is for a pre-operative visit please allow additional time for scheduling and counseling of your surgery.

Completing the task list for the items that apply to you will assure you of receiving the most thorough and professional care possible and in a very efficient manner.

We look forward to your visit!

PATIENT INFORMATION

DEMOGRAPHICS

NAME LAST FIRST MI				DATE	
STREET ADDRESS				SOCIAL SECURITY #	
CITY	STATE	COUNTY	ZIP CODE	SPECIAL NEEDS (CIRCLE ONE) WHEEL CHAIR WALKER HEARING IMPAIRED TRANSLATOR LANGUAGE _____ OTHER _____	
HOME PHONE ()	WORK PHONE ()		BIRTHDATE	AGE	SEX
EMPLOYER NAME/ADDRESS		POSITION	MARITAL STATUS (CIRCLE ONE) MARRIED DIVORCED SINGLE WIDOWED		
SPOUSE			WORK PHONE		
EMERGENCY CONTACT			EMERGENCY PHONE		

BILLING

GUARANTOR (FINANCIALLY RESPONSIBLE PERSON)				RELATIONSHIP TO PATIENT (CIRCLE ONE) SELF SPOUSE PARENT OTHER	
STREET ADDRESS				PHONE ()	
CITY			STATE	ZIP CODE	
PRIMARY INSURANCE	POLICY HOLDER	POLICY ID#	SOCIAL SECURITY #		INSURED'S B/D
SECONDARY INSURANCE	POLICY HOLDER	POLICY ID#	SOCIAL SECURITY #		INSURED'S B/D
SEND WORKERS COMPENSATION TO		AUTHORIZED BY/POSITION		DATE OF INCIDENT	

REFERRAL

WHOM MAY WE THANK FOR TELLING YOU ABOUT OUR PRACTICE? NAME:	(CIRCLE ONE) FRIEND/FAMILY	NEWSPAPER	RADIO	TV
	YELLOW PAGES	WEBSITE	MOVIE AD	HEALTH FAIR
I GIVE MY PERMISSION FOR MOYES EYE CENTER TO SEND A THANK YOU LETTER TO MY REFERRAL. SIGNATURE:	INSURANCE	OTHER _____		
PRIMARY CARE DOCTOR NAME	MD/DO _____			
STREET ADDRESS	OPTOMETRIST _____			
	PHONE NUMBER			
	CITY	STATE	ZIP CODE	

HEALTH HISTORY

- Yes No
- Asthma _____
 - Kidney Disease _____
 - Tuberculosis _____
 - Diabetes _____
 - Migraines _____
 - Psychiatric Disorder _____
 - Nervous Disorder _____
 - Heart Disease _____
 - Ulcer _____
 - High Blood Pressure _____
 - Do you smoke? _____
 - Do you drink? _____
 - Taken any illegal substances within the last 12 months? _____

- Yes No
- Head or Spinal injuries _____
 - Seizures, Convulsions, or Fainting _____
 - Extensive Confinement by Illness or Injury _____
 - Temporal Arteritis _____
 - Carotid Artery Disease _____
 - Stroke _____
 - HIV _____
 - Liver Disease _____
 - Rheumatoid Arthritis _____
 - Cancer _____
 - Sickle Cell Anemia _____
 - Other Diagnosed Health Problems _____

Please list all Medications you are **currently taking**:

Please list all Medications you are **allergic to**:

YOUR OCULAR HISTORY

- Yes No
- Cataracts
 - Glaucoma
 - Corneal Disease
 - Retinal Disease

- Yes No
- Cataract Surgery
 - Glaucoma Surgery
 - Corneal Surgery
 - Retinal Surgery

- Yes No
- Crossed eyes / Lazy eye
 - Iritis / Uveitis
 - Eye Muscle Surgery
 - Other: _____

FAMILY HISTORY

- Yes No
- Cataracts
 - Glaucoma
 - Corneal Disease

- Yes No
- Macular Degeneration
 - Retinitis Pigmentosa
 - Diabetes

- Yes No
- Heart Disease
 - Stroke
 - Retinal Detachment
 - Other: _____

SURGICAL HISTORY (please include date & type)

Name: _____ Date: _____

Tech initial & date _____

Agreement of Responsibility

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductibles and co-insurance will be collected at check in. Glasses prescriptions are considered "routine services" and are not covered by most "medical" health insurances. Please be prepared to pay for this service at your appointment. I understand that I am financially responsible for charges not covered by my insurance company.

Release of Information/Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me.

Medicare Authorization

I request payment of authorized Medicare benefits be made on my behalf to Moyes Eye Center, PC, for any services furnished to me by that physician/supplier. I authorize the holder of medical information, about me, to release to Medicare and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that 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 or electronically submitted claims, my signature authorizes the release of the information to the insurer to the agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Medigap Authorization

The following is to be filled out if you have a Medigap insurance policy for which you wish to assign benefits. A Medigap or Medicare Supplemental policy is a health insurance policy or other health plan, offered by a private company, to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered by an employer to employees or former employees, as well as a policy or plan offered by a labor organization to members or former members.

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her judgement as it pertains to my eyecare.

This agreement is in effect until revoked in writing by the patient.

Name: _____ Date: _____

Signature: _____

Moyes Eye Center
HIPAA PATIENT NOTICE

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a federal law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, employers
- Healthcare Transaction & Code Sets for transmitting data electronically
- Privacy regulations over disclosure and use of health information
- Security regulations over protections of electronic health information

It is our policy to not release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or the telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone. If you would like information released to someone other than yourself please complete the following:

I authorize Moyes Eye Center to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever the information changes.

Home telephone	yes _____	no _____
Answering machine	yes _____	no _____
Work telephone	yes _____	no _____
Voice mail	yes _____	no _____
Cell phone and/or voice mail	yes _____	no _____
Pager	yes _____	no _____
Can we fax medical records for referrals?	yes _____	no _____

Please list names of people we can discuss your medical care with:

Spouse: _____ yes _____ no _____

Parent: _____ yes _____ no _____

Other: _____

Please give name and relationship such as boyfriend, sister, etc.

Signature Patient/Guardian

Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of Moyes Eye Center Notice of Privacy Practices.
Patient Name

I, _____, refuse to accept a copy of Moyes Eye Center Notice of Privacy Practices.
Patient Name

Signature of Patient

Date