St. Cloud Eye Care

Patient Registration Form

Patient Information

Last Name: _____ First Name: _____ MI___ SS#:_____

Address:_____ City:_____ State:_____ Zip:_____
(please include Apt #)
Birth Date:_____ Home or Cell#_____ Work #_____

Gender: ☐ MALE ☐ FEMALE Marital Status: _____

Employer:_____Occupation:_____

Email Address:_____

How did you learn about our office?_____

Emergency Contact:_____ Phone #_____Relationship:_____

If patient is under 18 years of age: Name of parent /Legal guardian.

Name: _____ Date of Birth: _____ Relationship: _____
Phone #_____

Name: _____ Date of Birth: _____ Relationship: _____
Phone #_____

Insurance Information: Please provide both insurances

Medical Insurance: _____ ID #_____

Policy Holder Name:_____ Birth Date:_____ SS#_____

Vision Insurance: _____ ID #_____

Policy Holder Name:_____ Birth Date:_____ SS#_____

PAYMENT FOR THE DOCTOR IS REQUIRED AT THE TIME OF SERVICE.

If you are paying by check, we do require a valid driver's license. Returned checks and withdrawn credit card transactions will be assessed a **$50.00** service charge.

I certify that the above information is true and accurate. I hereby assign or transfer payments benefits made to me and my behalf to St Cloud Eye Care for any services furnished to me by this physician/supplier. I further agree that I am responsible for payment or charges incurred by me that are not covered by my insurance or for which my insurance has paid me. I understand that professional services are not refundable.

Patient/Legal Representative (Print): _____
Patient/Legal Representative Signature: _____
Relationship to patient (If Minor): _____ Date: _____

St. Cloud Eye Care

Medical Eye Exam VS Vision Exam

With constant changes to how insurance works we are trying to be as transparent as possible with how your visit is scheduled and billed. We are hoping this explanation will help eliminate any confusion about your visit today.

How your exam will be submitted to your insurance will depend not only upon what you tell the doctor but also what the doctor finds upon examination. In most cases vision plans **do not** cover medical exams, and medical plans **do not** cover vision exams. For insurance purposes, eye examinations are divided into two categories:

Medical Eye Exams (Medical Insurance)

These exams are considered medical eye examination whenever a patient is being evaluated, followed, or treated for a medical condition or symptom. The condition or symptom can be elicited by the patient during evaluation of the patient's history or found during the examination by the doctor. Examples that require billing to medical insurance include but are not limited to: Diabetes, Dry Eye, Glaucoma, Glaucoma Suspect, Macular Degeneration, Floaters, Cataracts, Eye irritation, Eye itching, Amblyopia, Strabismus (Lazy eye), High Myopia, Eye infections, Eye injuries.

If you have previously been diagnosed with a medical eye or systemic condition you are not eligible for a vision exam.

Vision Exam (Vision Insurance)

These exams are for patients who have NO eye diseases or symptoms. Vision will be examined for any needed correction (eyeglasses or contact lenses). The doctor will screen your eyes for diseases and find NO medical problems. Glasses and contact lens prescriptions may be updated. If the doctor sees indicators of eye disease, you will be asked to return for additional testing and evaluation through your medical insurance.

Please choose one of the following:

☐ I have an underlying eye disease or symptoms of an underlying eye disease. I understand that my exam will be billed to my medical insurance. If I would like to get my prescription updated on the same visit I understand that I am responsible for the refraction cost of $40.00 not covered by my medical plan. If I wish to do contacts, there is also a separate fee for which I am also responsible for.

☐ I wish to be evaluated for any needed correction of my vision in the form of glasses and/or contact lenses. I do not have any underlying conditions or symptoms to be evaluated. I understand that my exam will be billed to my vision insurance. I am responsible for any charges not covered by my vision insurance.

Patient/Legal Representative (Print): _____
Patient/Legal Representative Signature: _____
Relationship to patient (If Minor): _____ Date: _____

St. Cloud Eye Care

MEDICAL QUESTIONAIRE / EYE HISTORY

Reason for this visit: Choose 1

☐ Vision exam for glasses ☐ Vision exam for glasses and contact lens

☐ Medical Eye Exam: _____

Review of Systems
Please mark beside any condition you currently have.

Constitutional

☐ Developmental Disabilities

☐ Cancer Type:_____

☐ Unintentional Weight Loss

☐ Pregnant: How far along _____

ENT

☐ Hearing Loss

☐ Sinusitis

☐ Dry Mouth

☐ Laryngitis

Neurological

☐ Multiple Sclerosis

☐ Epilepsy

☐ Cerebral Palsy

☐ Tumor

☐ Migraine

Psychological

☐ Depression

☐ Attention Deficit

☐ Anxiety Disorder

☐ Bipolar Disorder

Cardiovascular

☐ Hypertension

☐ High Cholesterol

☐ Stroke/CVA

☐ Heart Disease

☐ Vascular Disease

☐ Congestive Heart Failure

Respiratory

☐ Asthma

☐ Bronchitis

☐ Emphysema

☐ Chronic Obstruction

☐ Sleep Apnea

Gastrointestinal

☐ Crohn's

☐ Colitis

☐ Ulcer

☐ Acid Reflux

☐ Celiac Disease

Genitourinary

☐ Kidney Disease

☐ Prostate Disease

Musculoskeletal

☐ Arthritis

☐ Osteoarthritis

☐ Fibromyalgia

☐ Rheumatoid Arthritis

☐ Muscular Dystrophy

☐ Osteoporosis

☐ Gout

Dermatological

☐ Eczema

☐ Rosacea

☐ Psoriasis

Endocrine

☐ Type 2 Diabetes

☐ Type 1 Diabetes

☐ Thyroid Dysfunction

☐ Hormonal Dysfunction

Hematologic/Lymphatic

☐ Anemia

☐ Large-Volume Blood Loss

☐ Ulcer

Allergic/Immune

☐ Environmental Allergies

☐ Lupus

☐ Sjogren's Syndrome

☐ Herpes Simplex/Cold Sores

☐ Herpes Zoster/Shingles

☐ None of the above

☐ Other not listed: _____

St. Cloud Eye Care

Is there any systemic family history of any conditions listed above? Please list relative for the condition.

_____
_____
_____

Please list all medications you may be taking including eye drops, hormones, over the counter, and birth control (If you don't know the name of the medication, please list the reason for the medication):

_____
_____
_____

Please list any food or medication allergies:

_____
_____
_____

Personal Ocular History

Last vision exam date: _____

Do you wear glasses? ☐ **Yes** ☐ **No**

If yes, how old are they? _____

Do you wear contact lenses? ☐ **Yes** ☐ **No**

If yes, what brand are they? _____

How old is your current pair? _____

How many years have you worn contact lenses? _____

Do you have any of the following vision concerns? ☐ None

☐ Blurry Vision ☐ Eyestrain ☐ Nearsighted ☐ Farsighted ☐ Astigmatism

☐ Poor Night Vision ☐ Glare ☐ Distorted Vision

Please list any additional vision concerns: _____

Do you have any of the following eye health concerns and/or conditions: ☐ None

☐ Redness ☐ Burning ☐ Itching ☐ Tearing/Watering ☐ Discharge ☐ Dryness

☐ Eye Pain ☐ Eye Soreness ☐ Flashes and/or Floaters ☐ Contact Lens Overwear

☐ Eye Infection/Inflammation ☐ Eye Trauma/Injury ☐ Cataracts ☐ Glaucoma

☐ Macular Degeneration ☐ Diabetic Retinopathy ☐ Keratoconus ☐ Lazy Eye

☐ Dry Eye ☐ Retinal Condition ☐ Blindness ☐ Color Blindness

Please list any additional diagnosed ocular conditions: _____

St. Cloud Eye Care

If you marked any ocular conditions, are you currently seeing a specialist? ☐ **Yes** ☐ **No**
If yes, please list specialist name and phone number:
_____
_____
_____

Is there any ocular family history of any conditions listed above? Please list relative for the condition.
_____
_____
_____

Have you ever had any ocular surgeries? ☐ **Yes** ☐ **No**
If yes, please list:
_____
_____
_____

Social History
Occupation: _____
Hobbies: _____
Approximately how many hours do you spend on a computer daily? _____

Tobacco Use: ☐ None ☐ Former Smoker ☐ Every day Smoker ☐ Some day smoker
☐ Smokeless Tobacco

Alcohol Use: ☐ None ☐ Social Use ☐ 1-2 drinks a day ☐ Above average use
☐ Alcohol Dependence

Cannabis Use: ☐ None ☐ Recreational Use ☐ Medical Use

I certify that the above information is true and accurate.

Patient/Legal Representative (Print): _____
Patient/Legal Representative Signature: _____
Relationship to patient (If Minor): _____ Date: _____

St. Cloud Eye Care

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a means by which a third-party payer can verify that services billed were actually provided
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been offered a copy of the *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing except to the extent that the organization has already taken action in reliance thereon.

Patient/Legal Representative (Print): _____
Patient/Legal Representative Signature: _____
Relationship to patient (If Minor): _____ Date: _____

Thank you for your confidence in our professional services and practice.
We look forward to serving you.

St. Cloud Eye Care

Office Policies

1. **Professional Services Are Non-Refundable**
2. All completed orders should be picked up within **90 days** following notification, If not picked up; the material(s) will be disposed of.
3. We are not responsible for glasses or contacts that are not picked up within **90 days**. **Payments or deposits will not be refunded.**
4. Contact lens fitting/evaluation has to be done within **60 days** of the routine examination. Otherwise additional fees will apply. Any evaluation over **6 months** from routine examination will require whole new exam in addition to the contact lens fitting/evaluation.
5. Once contact lenses are finalized by the doctor, **no changes can be made** to the powers or brand of the contacts.
6. All contact lens follow-ups within **60 days** of a contact lens exam will be at no charge. However, **any follow-up visits after 60 days from the date of the contact lens exam will be charged the regular fitting fee.** Anything over **6 months** will require a new exam fee in addition to the fit.
7. Only boxes that are unopened, in resalable condition, free of markings, dents, or damages will be exchanged or refunded within **30 day**s of purchase. **NO EXCEPTIONS**
8. Prescription re-checks within **90 days** of exam date will be at no charge. **All re-checks more than 90 days after the date of exam, but not more than 6 months, will be charged a refraction fee.** Thereafter, a new exam is required.
9. We do require a deposit of **50%** for all orders to get started and all balances must be paid in full when picking up material(s).
10. Patients may use own frames for orders, however for all orders of patients own frames, **we are NOT** responsible financially if the glasses break going through the lab, are stolen, or are lost during the process of completing the order.
11. Often we have little to no control over the amount of time it will take to manufacture the eyewear order. The average turnaround time is **14 business days** but rest assured we will call you as soon as your order is received.
12. **Prescription glasses are made to fit your needs only, they are a custom-made medical device. NO returns will be permitted.**
13. **OFFICE CANCELLATION POLICY:** We do understand that there are times when you must miss an appointment due to emergencies, obligations from work or family. However, when you do not call to cancel an appointment in advance, you are preventing another patient from being seen. **IF AN APPOINTMENT IS NOT CANCELLED 24 HOURS IN ADVANCE YOU WILL BE CHARGED A TWENTY-FIVE DOLLARS ($25.00) FEE; THIS WILL NOT BE COVERED UNDER YOUR INSURANCE.**

By signing below, you are acknowledging and accepting our office policies. If you have any questions regarding this form, please speak with one of our associates before signing.

Patient/Legal Representative (Print): _____
Patient/Legal Representative Signature: _____
Relationship to patient (If Minor): _____ Date: _____

St. Cloud Eye Care

Child Medical Consent

Patient name: _____ **Date of Birth:** _____

We understand there are times when the parent or legal guardian cannot be present to bring the child to his/her appointment. Unfortunately, without parental consent your child will not be seen at our facility. In the event of an emergency, where for one reason or another you the parent cannot be present, who do you authorize and give consent to bring your child to their appointment?

Name: _____ Phone number: _____

Date of Birth: _____ Relationship to patient: _____

Name: _____ Phone number: _____

Date of Birth: _____ Relationship to patient: _____

Name: _____ Phone number: _____

Date of Birth: _____ Relationship to patient: _____

By signing below, you are giving consent to the individuals listed above to bring your child and make any medical decisions on your behalf and that of our child. Please understand if anyone not listed brings your child to our facility, your child will NOT be seen. You have the right to revoke any individual at any time. We will need a letter in writing if this occurs. A legal form of identification is required by all individuals listed at the time of visit.

Patient/Legal Representative (Print): _____
Patient/Legal Representative Signature: _____
Relationship to patient (If Minor): _____ Date: _____

St. Cloud Eye Care

Family Release Form

To help us stay within the guidelines of HIPAA, please list below any person that you authorize us to disclose your Protected Health Information with, including but not limited to billing information and dispensing of prescriptions. Please provide all the information requested.

(Patient Information)

Patient Name: _____ Date of birth: _____

SSN: _____ Phone number: _____

(Authorized Individuals)

Name: _____ Phone number: _____

Date of Birth: _____ Relationship to patient: _____

Name: _____ Phone number: _____

Date of Birth: _____ Relationship to patient: _____

Name: _____ Phone number: _____

Date of Birth: _____ Relationship to patient: _____

This authorization will continue until it is withdrawn, by me (the patient), in writing.

Patient Signature: _____ **Date:** _____

(Office use only)

Use this space for consent withdrawals only: Need written letter from patient.

_____ _____

Date consent revoked Staff Signature