

Patient Registration Form

Patient Information

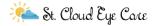
Last Name:	First Name:	MI SS#:
Address:	City:	State: Zip:
(please include Apt # Birth Date:) Home or Cell#	Work #
Gender: 🗌 MALE 🗌 FEMA	ALE Marital Status:	
Employer:	Оссир	ation:
Email Address:		
How did you learn about our o	office?	
		Polotionship
	Phone # Phone Phone Phone Phone Phone Phone Phone Phone P	
<u>If patient is under 18 ye</u> Name: Phone #	ears of age: Name of parent /L Date of Birth:	_egal guardian. Relationship:
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If patient is under 18 ye Name: Phone # Name: Phone # Insurance Information:	Pars of age: Name of parent /L Date of Birth: Date of Birth:	<u>egal guardian.</u> Relationship: Relationship:
If patient is under 18 ye Name: Phone # Phone # Insurance Information: Medical Insurance:	Please provide both insurant	<u>egal guardian.</u> Relationship: Relationship: <u>Ces</u>
If patient is under 18 ye Name:	Please provide both insuran	<u>egal guardian.</u> Relationship: Relationship: Relationship: te: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 Returned checks and withdrawn credit card transactions will be assessed a **\$50.00** service charge.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:



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)

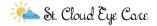
These exams are for patients who have NO eye diseases or symptoms. Vision will be examined for any needed correction (eyeglasses or contact lenses). The doctor will screen your eyes for diseases and find NO medical problems. Glasses and contact lens prescriptions may be updated. If the doctor sees indicators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

Please choose one of the following:

 \Box 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.

 \Box 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:	



MEDICAL QUESTIONAIRE / EYE HISTORY

Reason for this visit: Choose 1

 \Box Vision exam for glasses \Box Vision exam for glasses and contact lens

Medical Eye Exam: _____

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

Constitutional

□ Developmental
Disabilities
\Box Cancer
Туре:
□ Unintentional Weight
Loss
\Box Pregnant: How far
along

ENT

Hearing Loss
Sinusitis

- □ Dry Mouth
- \Box Laryngitis

Neurological

- \Box Multiple Sclerosis
- □ Epilepsy
- □ Cerebral Palsy
- □ Tumor
- □ Migraine

Psychological

- □ Depression
- \Box Attention Deficit
- □ Anxiety Disorder
- □ Bipolar Disorder

 \Box Other not listed: _

Cardiovascular

- □ Hypertension
- \Box High Cholesterol
- □ Stroke/CVA
- \Box Heart Disease
- □ Vascular Disease
- \Box Congestive Heart
- Failure

Respiratory

- □ Asthma □ Bronchitis

- \Box Chronic Obstruction
- \Box Sleep Apnea

Gastrointestinal

- \Box Crohn's
- \Box Colitis
- □ Ulcer
- \Box Acid Reflux
- \Box Celiac Disease

Genitourinary

- \Box Kidney Disease
- \Box Prostate Disease

Musculoskeletal

- \Box Arthritis
- \Box Osteoarthritis
- □ Fibromyalgia
- □ Rheumatoid Arthritis
- □ Muscular Dystrophy

□ Gout

Dermatological

- 🗆 Eczema
- \Box Rosacea
- \Box Psoriasis

Endocrine

- □ Type 2 Diabetes
- □ Type 1 Diabetes
- \Box Thyroid Dysfunction
- □ Hormonal Dysfunction

Hematologic/Lymphatic

Anemia
 Large-Volume Blood
 Loss
 Ulcer

Allergic/Immune

- □ Environmental Allergies
- Lupus - Ciogran's Cundres
- □ Sjogren's Syndrome
- □ Herpes Simplex/Cold Sores
- □ Herpes Zoster/Shingles

 \Box None of the above

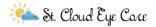


Is there any systemic family history of any conditions listed above? Please list relative for the condition.

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? D Yes D No If yes, how old are they?	
Do you wear contact lenses? □ Yes □ No If yes, what brand are they?	
Do you have any of the following vision concer	ns? 🗆 None
□ Blurry Vision □ Eyestrain □ Nearsighted	□ Farsighted □ Astigmatism
\Box Poor Night Vision \Box Glare \Box Distorted V	ision
Please list any additional vision concerns:	
Do you have any of the following eye health co	ncerns and/or conditions:
□ Redness □ Burning □ Itching □ Tearin	g/Watering 🗆 Discharge 🗆 Dryness
□ Eye Pain □ Eye Soreness □ Flashes and/o	or Floaters 🛛 Contact Lens Overwear
□ Eye Infection/Inflammation □ Eye Trauma/	Injury 🗆 Cataracts 🗆 Glaucoma
□ Macular Degeneration □ Diabetic Retinopa	thy 🛛 Keratoconus 🗆 Lazy Eye
□ Dry Eye □ Retinal Condition □ Blindness	



If you marked any ocular conditions, are you currently seeing a specialist? \Box Yes \Box 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? \Box Yes \Box No

If yes, please list:

Social History

Occup	atic	on:		
Hobbie	es:			
	•		1	1 11 0

Approximately how many hours do you spend on a computer daily?

 $\hfill\square$ Smokeless Tobacco

Alcohol Use:	□ None	□ Social Use	\Box 1-2 drinks a day	\Box Above average use
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 \Box Alcohol Dependence

Cannabis Use: \Box None \Box Recreational Use \Box 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:



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

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.



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 days** 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).
- 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 <u>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.</u>

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:



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:



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 contir	nue 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	