CRAWFORD FAMILY EYE CARE, DR. KEVIN CRAWFORD

PERSONAL AND MEDICAL BACKGROUND FOR:

Patient Name: ____DATE: ______________________________

Primary Language?________________________________
Race? ____________________________________ Please check one: ☐ Hispanic ☐ Not Hispanic
☐ Check here to opt out of answering the above questions.

1) What is the reason for your visit today? ____
____
____

2) Do you currently wear GLASSES ☐ CONTACTS ☐ Neither ☐
For contact lens wearers: Would you like a contact lens year prescription/renewal with this exam? Yes ☐ No ☐
For NON-contact lens wearers: Are you interested in trying contacts? Yes ☐ No ☐
**A contact lens exam is subject to a service/fitting fee which may or may not be covered by insurance.

3) Are you experiencing any problems with your eyes or vision today?
☐ Itching ☐ Dry Eye ☐ Burning ☐ Watering ☐ Other _________________________________

4) At our office, we offer OPTOS testing. Optos is a painless (no dilation) scan of the back of the eye that we recommend to all patients. It details the overall health of the eye and may find preliminary problems or diseases. Your results will be discussed during your exam. Insurance does not cover this test for non-medical reasons, and it costs $40. Would you like this test today? ☐ Yes ☐ No

5) Have you ever had any serious injuries or illness to your eyes or head? ☐ Yes ☐ No
If yes, please explain: ____
____

6) Are you a smoker? ☐ Yes, amount _____________________________ ☐ No

7) Do you drink alcohol? ☐ Yes, amount: __________________________________ ☐ No

8) CURRENT MEDICATIONS: ____
____
____
____

9) ALLERGIES (Drug allergies, environmental allergies, latex sensitivity, etc): ______________________________
____
____

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MEDICAL CONDITIONS	SELF: Currently	FAMILY, Please list relation
Cancer		
Diabetes, Type 1		
Diabetes, Type 2		
High Blood Pressure		
High Cholesterol		
Stroke		
Hyperthyroid		
Hypothyroid		
Cataracts		
Macular Degeneration		
Glaucoma		
Retinal Detachment		
Other		

Are you pregnant? Yes ☐ **No** ☐

What is your current occupation? ____
Hobbies, sports or recreational activities you are involved in: _______________________________
____

MEDICAL INFORMATION RELEASE FORM

(HIPPA RELEASE FORM)

PATIENT NAME:____DOB:__________________
If patient is a minor, please add name(s) of parent(s) that we may share eye care records with:

Parent(s) Name(s): ____

Email/Phone Contact Information: ____

Adults:
**If only the above patient may have access to his/her eye care records (including permission to pick up contacts/glasses/billing/invoices), please initial here X___________ and sign below.

**If you would like to authorize another person to have access to your eye care information/records, including permission to pick up glasses/contacts/invoices, etc. please fill out the following information:

I, the above stated patient, authorize: Crawford Family Eye Care, 1295 E 151st St, Ste 3, Olathe, Ks. 66061 to disclose all eye care/medical records, including encounter details and invoices to:

Name: ____ Relationship to Patient:_________________________

Name: ____ Relationship to Patient:_________________________

Patient or Parent Signature:____Date:_______________________
*Authorization will be in effect until next appointment

Medical Vs. Vision Insurance

Medical Insurance: When a medical condition exists such as (but not limited to) cataracts, glaucoma, dry eyes, diabetes, high blood pressure, or any other conditions related to the health of the eye, it will be necessary for the doctor to perform a full and comprehensive ocular health exam. This exam may include further testing beyond the scope of a routine eye exam. With a medical diagnosis, your exam and testing will be billed to your medical insurance, and you will be responsible for any co-pays, deductibles and/or co-insurance as dictated by your specific plan. If you are diabetic, your exam will be billed to your medical insurance.

Vision Care Insurance: Vision coverage for a routine examination is designed to provide a screening evaluation of the eye to determine a prescription for glasses only. This evaluation is not a comprehensive ocular health examination and excludes any testing to diagnose, evaluate and follow medical issues. This evaluation also does not include a contact lens evaluation, or any fees associated with contact lenses.

Contact Lenses: Contact lens services are considered to be elective and therefore not covered by medical insurance and possibly not covered by vision insurance. A contact lens prescription is valid for one year from the date of issue. In order to maintain a current contact lens prescription, you must have annual contact lens evaluations with your doctor. Payment for a contact lens evaluation, whether performed independently or as part of your comprehensive eye exam, is expected at the time of service. A separate contact lens agreement will be signed prior to a contact lens fitting or refitting.

Refractions: A refraction is the portion of the examination process wherein the doctor or technician places various lenses in front of your eyes to determine your best corrected vision for your spectacle prescription. This service is considered to be a non-covered service by Medicare. The fee for this service is $65 and is collected when a refraction is preformed whether or not you have had a change in your prescription. A spectacle prescription is valid for one year from the date of the refraction; you will need to have refractions as part of your exam in order to maintain a current prescription.

Optos: An Optos test is a portion of the examination where the eye is scanned to show the health of the eye or detect disease. Some diseases it can detect is macular degeneration, glaucoma, retinal tears or detachments. This test is recommended to all patients but is not required unless the patient is diabetic. The Optos scan is not cover by Vision insurance. If the patient is diabetic, then the services will be billed to the Medical Insurance. The fee for a non-diabetic patient for this service is $40 and is collected at the time the scan is performed.

Financial Policy

Thank you for choosing our office as your vision care provider. The following is a statement of our financial policy. If you have any questions or concerns, please do not hesitate to discuss them with our staff.

Insurance Coverage: Initial: _____

It is your responsibility to provide our office with accurate information for billing your insurance at the time of service. It is also your responsibility to know if you visit is covered by your insurance plan fully, partially, or not at all. For example, you may be covered under your primary healthcare plan and for additional vision services under a different carrier as well. It is your responsibility to know if you have separate coverage. If, at the time of service, you do not provide us with your current coverage and later make us aware of additional coverage you will be responsible for any and all charges. We will gladly provide you with an itemized invoice to submit to your insurance for reimbursement. Information of this type is only 100% accurate if you obtain it directly from your insurance provider. In the event you do not confirm this information and the insurer refuses full or partial payment, you will be responsible for the cost of the services provided.

Routine and Medical Eye Exams: Initial: _____

Our office participates with certain plans for routine eye exams. A routine eye exam is, by definition, a "Well Vision" exam for people with no eye disease or symptoms of disease. Your eye will be examined for any needed correction (glasses, contacts, etc.) or any potential indicators of eye disease. If the Doctor detects any medical conditions, which include but are not limited to glaucoma, cataracts, etc., the exam may become a medical eye exam and will be submitted to your medical insurance. Please note that some insurance plans consider a routine eye exam to be a non-covered service.

Glasses and Contact Lens Exams: Initial: _____

Exams for glasses and contact lenses are separate exams. If you desire to have both exams during your visit, you will be charged a contact lens fitting fee for a contact lens exam. Contact lens fitting fees may not be covered under your insurance plan. We require this fee to be paid in full at the time of service. We have the right to reserve your contact lens prescription until the fitting fee has been paid.

Amounts Due from Patient: Initial: _____

Insurance co-payments will be collected at the time of service. If we do not participate with your insurance plan, you are to provide full payment for all services performed during your visit. The fee for a Patient who is uninsured or who has an insurance plan we do not participate with would be $119. This fee will be due at the time of service. If you are using insurance, we will make every effort to collect full and accurate fees specific to your plan. However, if there is a fee that your insurance charges and we did not collect it at the time the order was placed it must be paid in full before the glasses or contacts will be dispensed.

Amounts Determined "Not Covered": Initial: _____

In the event a health plan determines a service to be "not covered," you will be responsible for the complete charge. An example of this is the refraction. Most medical insurance plans, including Medicare, do not cover refractions. Our office will collect the refraction fee and any co-payments at the time of service.

By signing this form, I consent to the use and disclosure of protected health information about myself for treatment, payment, and health care operations, and/or as required by law. Crawford Family Eye Care provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

______________________	______________________	______________
Printed Patient Name	Patient or Guardian Signature	Date