

# SUMNIGHT EYE CARE- NEW PATIENT INFORMATION

Please fill out the information to the best of your ability. Complete and accurate information allows us to give you the best medical care possible. This form will need to be updated every 3 years per insurance regulation.

## Personal Demographic Information

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender (must include for Tricare): \_\_\_\_\_

Preferred Language: \_\_\_\_\_ Interpreter Needed? YES [ ] NO [ ]

Mailing Address: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

May we leave a detailed messages regarding care? YES [ ] NO [ ]

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer phone #: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Partner/ Spouse's Name: \_\_\_\_\_

Primary Care Physician (PCP): \_\_\_\_\_

Primary Care Facility: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Phone #: \_\_\_\_\_

May we disclose medical information in the event of an emergency? YES [ ] NO [ ]

Preferred Pharmacy and Location: \_\_\_\_\_

## Insurance Information (Please fill out even if we have a copy)

Primary Insurance: \_\_\_\_\_

Member ID #: \_\_\_\_\_

Group ID #: \_\_\_\_\_

Policy Holder: [ ] Same as patient

[ ] Other: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Member ID #: \_\_\_\_\_

Group #: \_\_\_\_\_

Policy Holder: [ ] Same as Patient

[ ] Other: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

## History of Present Illness and Chief Complaint

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Last Eye Exam?: \_\_\_\_\_

Please note: As a surgical clinic accepting only medical insurance, we address medical issues and generally do not perform routine screening exams. Please describe what we are addressing at your visit today.

What issue can we address today? \_\_\_\_\_

### Onset (When did symptoms start)

\_\_\_ hours/ days/ weeks/ months/ years [ ] unsure

### Location (Where is the issue?)

[ ] Right Eye [ ] Left eye [ ] Both Eyes [ ] Unsure [ ] Other: \_\_\_\_\_

### Duration (How long do symptoms last?)

[ ] Constant [ ] Fluctuates [ ] Intermittent [ ] Unsure

### Severity (How bad are symptoms)

[ ] Absent [ ] Mild [ ] Moderate [ ] Severe [ ] Debilitating

### Quality (Description/ What does it feel like?) CHECK ALL THAT APPLY

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Aching           | <input type="checkbox"/> Crusting                                    | <input type="checkbox"/> Flaky                  | <input type="checkbox"/> Haloes              |
| <input type="checkbox"/> Blurry           | <input type="checkbox"/> Double Vision                               | <input type="checkbox"/> Flashes of Light       | <input type="checkbox"/> Headache            |
| <input type="checkbox"/> Burning          | <input type="checkbox"/> Discharge                                   | <input type="checkbox"/> Floaters               | <input type="checkbox"/> Itching             |
| <input type="checkbox"/> Bump             | <input type="checkbox"/> Distorted Vision                            | <input type="checkbox"/> Foreign Body Sensation | <input type="checkbox"/> Leathery Appearance |
| <input type="checkbox"/> Drooping         | <input type="checkbox"/> Dryness                                     | <input type="checkbox"/> Glare                  | <input type="checkbox"/> Light Sensitive     |
| <input type="checkbox"/> Missing Vision   | <input type="checkbox"/> Obstructed Vision                           | <input type="checkbox"/> Ocular Migraine        | <input type="checkbox"/> Redness             |
| <input type="checkbox"/> Spasm/ Twitching | <input type="checkbox"/> Stabbing Pain                               | <input type="checkbox"/> Swelling               | <input type="checkbox"/> Watering            |
| <input type="checkbox"/> Wavy Vision      | <input type="checkbox"/> Vision Loss (Central/ Temporary/ Permanent) |   |  |

Other: \_\_\_\_\_

### Vision (How well do you see even WITH glasses?)

- |   |  |
|---|--|
| <input type="checkbox"/> No Change                  | <input type="checkbox"/> Difficulty with distance vision             |
| <input type="checkbox"/> Everything is blurry       | <input type="checkbox"/> Vision Fluctuates through out the day       |
| <input type="checkbox"/> Difficult with near vision | <input type="checkbox"/> Vision worse in the morning but gets better |

### Timing (What triggers it?)

- |                                     |  |                                  |   |
|-------------------------------------|--|----------------------------------|---|
| <input type="checkbox"/> Allergies  | <input type="checkbox"/> Going Outside | <input type="checkbox"/> Rubbing | <input type="checkbox"/> Sleeping                   |
| <input type="checkbox"/> Blinking   | <input type="checkbox"/> Headlights    | <input type="checkbox"/> Lights  | <input type="checkbox"/> Waking up and opening eyes |
| <input type="checkbox"/> Wind/ Cold | <input type="checkbox"/> Wind/ Cold    | <input type="checkbox"/> Unsure  |   |

### Modifying Factors (What makes it better or worse?)

- |   |   |
|---|---|
| <input type="checkbox"/> Artificial Tears | <input type="checkbox"/> Cold Compresses                            |
| <input type="checkbox"/> Warm Compresses  | <input type="checkbox"/> Prescription Medication: _____ [ ] Nothing |

Has this happened before? [ ] Yes [ ] No [ ] Unsure



## SUMNIGHT EYE CARE- FINANCIAL POLICY

We are committed to providing you with the best possible eye care. As a courtesy, we will bill your medical insurance on your behalf.

**Payment for services is due at time of service**, unless payment arrangements have been made in advance.

- 1. You are responsible for understanding your insurance benefits.** Your insurance coverage is a contract between you, your employer, and/ or the insurance company but we can help clarify information for you.
- 2. HMO Patients: You are responsible for obtaining any and all referrals from your Primary Care Physician (PCP) and Authorization from your insurance plan, before arriving at your appointment.** Failure to do so can result in denial of your claim and you being responsible for the full balance of your bill.
- 3. Not all services are covered by medical insurance.** Medical and Vision insurance are NOT the same thing. A glasses prescription is usually not covered by medical insurance per insurance guidelines.
- 4. As the patient, you are responsible for payment for services received and all balances are your responsibility.** We will do our best to bill your insurance first. We accept cash, Visa, Mastercard, and personal checks payable to Andrew Sumnicht, MD. Convenient payment plans may be arranged.
- 5. Please make a secure online payment on our web site SUMNICHTEYE.COM.**
- 6. No-showing to an appointment is subject to a \$200 No-show fee. Late cancellation (less than 24 hours) will result in a \$100 fee. There will be a one time allowance before this fee is enforced. Three (3) no-show or late cancellation occurrences may result in dismissal from the practice.**
- 7. There will be a fee of \$60 for all non- sufficient funds checks.**
- 8. Past due accounts over 60 days may be charged a maintenance fee of \$5.00 per month.**
- 9. Past due accounts over 90 days may face collections proceedings.**

**We must emphasize that. as a medical care providers, our relationship is with you, not your insurance company. Any disputes between you and them must be resolved by you, the patient.** We will gladly discuss your proposed treatment and answer any questions related to your insurance.

We realize that temporary financial situations may affect timely payment of your account. If such issues do arise, we encourage you to contact us promptly for assistance in the management of your account. We are happy to make your visits more affordable for you and will work with you to establish a plan that can work for everyone.

Patient Signature (parent if minor): \_\_\_\_\_ Date: \_\_\_\_\_

## Notice of Privacy Practices

This **Notice of Privacy Practices** describes how your health information may be used and disclosed and how you may access your information.

- We keep a record of the health care services we provide you.
- You may ask for your records at any time.
- You may ask to correct or amend your record at any time.
- We will not disclose your medical records to others unless you sign a Release of Information medical records form, or if the law authorizes us to do so.
- Supplying medical records to an outside agency may result in processing and administrative fees.
- Insurance companies require that we keep a copy of your insurance card on file for identification purposes. A copy of this is kept in an secure internal database.
- We require a copy of Identification card on file to cross reference with your insurance information to reduce the risk of identity theft or improper use of insurance benefits. This copy is kept in a secure internal database.

By signing below, I acknowledge receipt of the **Notice of Privacy Practices**.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **AUTHORIZATION TO BILL- MEDICARE/ MEDIGAP/ MEDICARE ADVANTAGE/ COMPLETE**

I request that payment of Authorized Medicare benefits be made either to me or on my behalf to Andrew Sumnicht, MD, for any service furnished to me by that physician. I authorize release to the Centers for Medicare and Medicaid Services and its agents any medical information about me needed to determine the payments for related services.

**Does not apply**

\_\_\_\_\_  
Signature of Beneficiary (Patient), Guardian, or Personal Representative

\_\_\_\_\_  
Printed Name of Beneficiary (Patient), Guardian or Personal Representative

\_\_\_\_\_  
Date

# SUMNIGHT EYE CARE

## APPOINTMENT CANCELLATION/NO-SHOW POLICY

Thank you for trusting us with your eye health. When you schedule an appointment with Sumnacht Eye Care, we dedicate time to provide you with the best possible care.

Please note the following regarding appointment changes and fees:

- **Cancellation Policy:** If you need to change or cancel your appointment, please contact us at least **24 hours in advance**. This helps us accommodate other patients.
- **No-Show Fees (effective March 1, 2025):**
  - **First No-Show:** \$100 charge for established patients who do not show up and do not cancel or change their appointment with the required 24 hours in advance.
  - **Second No-Show:** \$150 charge for established patients who miss an appointment without proper notice a second time.
  - **Third No-Show:** Patients who miss three appointments without notice may be discharged from Sumnacht Eye Care.
  - **New Patients:** If you do not show up for your appointment, and do not contact us to cancel or reschedule your appointment, you will not be rescheduled.
- **Payment Responsibility:** The no-show fees are the responsibility of the patient and must be paid before or upon check in of your next appointment. These fees will not be billed to your insurance.
- **Emergency Situations:** We understand emergencies can arise. If you encounter an emergency that prevents you from attending your appointment, please contact us.
- **Sickness:** We understand that illnesses happen! We would prefer that patients stay home to recover, and to protect our staff and patients, by not coming to appointments when they are actively sick. Please call with as much notice as possible if you are sick.

Please call if you need to change or cancel your appointment. Reminder calls will go out 2 days in advance of your appointment. Voice mails left after hours will be honored as notice of cancellation.

**I have read and agree to the terms of the Cancelled Appointment/No-Show policy.**

**PATIENT:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_