SWEDBERG EYE CARE

OPHTHALMOLOGY CLINIC

21827 76th Avenue West, Suite 102, Edmonds, WA 98026 **(425) 778-2500** fax (425) 778-5600

PATIENT INFORMATION FORM

Please fill out the information to the best of your ability. Complete and accurate information allows us to give you the best service possible.

PERSONAL INFORMATION

Name: First: ________________________________ MI: ______ Last: ______________________________________

Date of Birth: ______________ Social Security # _________________ (Must include for Tricare) Gender: _________

Ethnicity / Language: ____

Do you need an interpreter (circle)? YES NO

CONTACT INFORMATION

Mailing address: ____

City: ____ State:____ Zip: ___________

Primary Phone #:________________________ Cell Phone #: ___________________________

May we leave a message that contains medical information on your cell phone (circle)? YES NO

Email address: ____

Employer: ______________________________________ Phone: ______________________

Marital Status: ______________Spouse's Name: ____________________________________

Emergency Contact: _________________________ Phone: _____________________________

Primary Care Physician: ______________________ Facility: __________________________

Referring Physician: ___________________________________ City: ___________________

Pharmacy _________________________ City: _______________ Phone:________________

Person Responsible for Payment: ____

DOB: ______________ Social Security #: ________________ Relationship: ______________

Phone: ___________________ Address: ____

City: ____ State: _______ Zip: ______________

INSURANCE INFORMATION

Primary Insurance: ___________________________ ID / Member Number: ___________________________

Group #: _____________________ Policy Holder: _______________________ DOB: __________________

Secondary Insurance: : ___________________________ ID / Member Number: ________________________

Group #: _____________________ Policy Holder: _______________________ DOB: __________________

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to Dr. Steven H. Swedberg, MD PS as well as release of any information by provider or insurance company required for this account.

PAYMENT: I agree that I am responsible for providing up to date health insurance information and am financially responsible for the balance remaining after insurance adjudication. I agree to make payment arrangements for any unpaid balances due after 30 days after the billing statement.

SIGNED: ____ DATE: ______________________

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NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGMENT

We keep a record of the health care services we provide you. You may ask for your records at any time. You may also ask to correct that record. We will not disclose your medical records to others unless you sign a release of medical records request form or if the law authorizes us to do so. Supplying medical records to outside agencies may result in a processing fee.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed and how you may access your information.

By signing below I acknowledge receipt of the **Notice of Privacy Practices**, and have been informed of our office **Financial Policy** and **Refraction Fee** on the previous page.

______________________________________ ______________
Patient or Legal Guardian Date

______________________________________ ______________
Printed Name Relationship

______________________________________ ______________
Printed name of person we may disclose medical information to in the case of an emergency. Relationship

Rev 4.2 11/19/2020

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FINANCIAL POLICY

We are committed to providing you with the best possible eye care. If you have medical insurance, we will bill your insurance carrier as a service to you. Swedberg Eye Care's payment policy is as follows:

Payment for services are due at that time the services are rendered unless payment arrangements have been arranged in advance. Understanding your health care insurance plan may be difficult but we are here to help.

1. Your insurance is a contract between you, your employer and the insurance company. **You need to make every effort to understand what your insurance will pay for and what they will expect you to pay for.**

2. **Referrals from your Primary Care Physician and Authorization from your Insurance Plan, are often required under your policy.** It is your responsibility to check with your insurance to see if any of these are required and to ask your Primary Care Physician for a referral to see another physician.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select services they will not cover. For example, **some insurance policies will not cover routine eye exams and refractions, thereby making you completely responsible for the charges**. A **Refraction** is the process of determining the eye's refractive error for an eyeglass prescription. This exam is not a covered service by **Medicare**, **Secure Horizons** or most other insurances. The **refraction fee is $70.00**.

4. As the patient, you are responsible for payment for services received. We will do our best to bill your insurance first. All balances are your responsibility. We accept cash, Visa, Master Card, Care Credit and checks payable to Dr. Steven H Swedberg, MD, PS. Convenient payment plans may be arranged.

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

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

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help.

There will be a fee of $30 for all NSF checks. Past due accounts over 60 days may be charged a minimum of $5.00 per month. Past due accounts over 90 days may face collection proceedings.

Name: ______________________________ Date: ______________________

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AUTHORIZATION TO BILL MEDICARE / MEDIGAP

Patient's Name______________________________________ Date of Birth ______________

Medicare Member ID #______________________________ Account # ________________

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Steven H. Swedberg, 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.

____ ___________________
Signature of Beneficiary, Guardian or Personal Representative Date

____ ____________________
Printed Name of Guardian or Personal Representative Date

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GLASSES PRESCRIPTION (REFRACTION) ACKNOWLEDGMENT

You will NOT be charged for or receive a Glasses Prescription (Refraction) unless the physician determines that it is necessary or you ask for a prescription.

By signing below you acknowledge that we have informed you of the following:

- **You may refuse the glasses prescription.**
- Medical insurance rarely pays for glasses prescriptions.
- Without a refraction, you will not receive a glasses prescription.
- The cost of the prescription is $70.00 and is due at the end of your visit.
- This fee in addition your copayment (if any.)
- If your insurance pays for the refraction you will be refunded.
- A refraction is used to determine if you are ready for cataract surgery.

I have read the above information and understand that my glasses prescription is a **non-covered service** by my insurance. I except full financial responsibility for the cost of this. I understand that the insurance copayment is separate from the refraction fee.

______________________________ ______________________________
Patient signature (Parent for minor) Date

☐ I acknowledge that I do not have a medical condition and I will be responsible for submitting any claims to vision insurance.

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HEALTH HISTORY

Patient Name: ________________________________ Date: __________________________

Medical History (check all that apply)

___ High Blood Pressure	___Hepatitis	___Glaucoma	___Retinal Detachment
___Heart Problems	___Thyroid Disease	___Keratoconus	___Strabismus
___Diabetes	___HIV Positive	___Cataract	___Eye Injury
___Arthritis	___Cancer	___Macular Degeneration	___Eye Surgery

Medications:	Medication Allergies:
____	______________________________
____	______________________________
____	______________________________
____	______________________________
____	______________________________

Please list all Eye Surgeries and any Recent /Past Major Surgeries:
____
____

Review of Systems:	YES	NO	If YES, please explain
Do you have any of the following problems:	___	___	____________________
Chronic fever, unexpected weight loss/gain, fatigue	___	___	____________________
Ear/nose/throat problems (e.g. hearing loss, sinus problems)	___	___	____________________
Heart Problems (e.g. chest pain, irregular heart beat)	___	___	____________________
High Blood Pressure	___	___	____________________
Respiratory problems (e.g. shortness of breath, wheezing)	___	___	____________________
Hay Fever	___	___	____________________
Gastrointestinal problems (e.g. abdominal pain, diarrhea)	___	___	____________________
Urinary problems (e.g. pain or discomfort, blood in urine)	___	___	____________________
Skin problems (e.g. rashes, excessive dryness)	___	___	____________________
Musculoskeletal problems (e.g. muscle aches, joint pain)	___	___	____________________
Neurologic problems (e.g. numbness, weakness, headaches)	___	___	____________________
Endocrine problems (e.g. diabetes, thyroid)	___	___	____________________
Psychiatric problems (e.g. depression, anxiety)	___	___	____________________

Family History:

___ Blindness	___Crossed/Lazy Eye	___Glaucoma
___Retinal Detachment	___ Cataract	___Macular Degeneration

Social History:

Tobacco Use:	___Former	___Currently	___Never
Alcohol History:	___Occasionally	___Daily	___Never