CENTRAL OHIO EYE PHYSICIANS AND SURGEONS

262 Neil Ave. Ste. 420, Columbus, Ohio 43215 • (614)224-4297 1-800-537-2000

PATIENT'S NAME_____ **MARITAL STATUS S M W D**

DATE OF BIRTH_____ **AGE**_____ **SEX**_____ **SOCIALSECURITY#**_____

ADDRESS_____ **HOME PHONE #** _____

CITY_____ **STATE**_____ **ZIP**_____ **CELL PHONE #**_____

EMAIL ADDRESS: _____

EMPLOYER _____ OCCUPATION_____ WORK PHONE #_____

NAME OF SPOUSE OR PARENT (IF PATIENT IS A CHILD) _____

EMERGENCY CONTACT_____ PHONE#_____

PLEASE DESCRIBE TYPE OF EYE PROBLEM YOU ARE HAVING_____

_____

PLEASE LIST ANY EYE INJURIES, SURGERIES, LASIK, OR LASER: _____

_____

DO YOU WEAR GLASSES? ☐ YES ☐ NO **DO YOU WEAR CONTACT LENSES?** ☐ YES ☐ NO

PLEASE LIST MEDICATIONS

Name	Dosage	How Often	Name	Dosage	How Often

ALLERGIES TO ANY MEDICATIONS? ☐ NO ☐ YES: _____

NAME/ADDERSS/PHONE OF PREFERRED PHARMACY_____

HAS ANYONE IN YOUR FAMILY HAD THE FOLLOWING CONDITIONS? (PLEASE CHECK)
☐ CATARACT ☐ GLAUCOMA ☐ MACULAR DEGEN. ☐ CROSSED EYES.

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS? ☐ NO ☐ YES (If yes please check)
☐ **DIABETES** IF YES WHAT WAS YOUR LAST A1C? _____
☐ **HIGH BLOOD PRESSURE** IF YES LAST BP READING _____/_____
☐ **BREATHING PROBLEMS** ☐ **HEART PROBLEMS** ☐ **HIV** ☐ **AIDS**

LIST ANY OTHER DISEASES: _____

RECENT SURGERIES: _____

PLEASE SEE OTHER SIDE

DO YOU SMOKE? ☐ YES ☐ NO
If so, how many? _____

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO
If so, how much? _____

DID YOU GET A PNEUMONIA VACCINE? ☐ YES ☐ NO
DID YOU GET THE FLU SHOT? ☐ YES ☐ NO

NAME & ADRESS OF REFERRING DOCTOR

_____

_____

NAME/ADDRESS/PHONE OF FAMILY DOCTOR

_____

_____

PRIMARY INSURANCE PROVIDER: _____
SUBSCRIBER NAME: _____ DATE OF BIRTH: _____
SUBSCRIBER SSN: _____ MEMBER ID: _____

SECONDARY INSURANCE PROVIDER: _____
SUBSCRIBER NAME: _____ DATE OF BIRTH: _____
SUBSCRIBER SSN: _____ MEMBER ID: _____

DO YOU HAVE VISION INSURANCE? ☐ **YES** ☐ **NO**

VISION INSURANCE PROVIDER: _____
SUBSCRIBER NAME: _____ DATE OF BIRTH: _____
SUBSCRIBER SSN: _____ MEMBER ID: _____

REFRACTIONS (A TEST USED TO EVALUATE AND OBTAIN YOUR BEST VISION) ARE USUALLY NOT COVERED BY MOST INSURANCE COMPANIES. THE PATIENT OUT-OF-POCKET RESPONSIBILITY FOR A REFRACTION IS $30.00. IF THERE ARE ANY OTHER CHARGES YOUR INSURANCE WILL NOT COVER, WE WILL ASK YOU TO SIGN A WAIVER FOR THESE SERVICES. AT THE TIME OF SERVICE, WE WILL COLLECT THESE OUT-OF-POCKET FEES. Please sign and date below that you have read and understand these statements.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Central Ohio Eye Physicians and Surgeons to furnish information to my insurance carriers and other Physicians and healthcare providers concerning my illness and treatments. I hereby assign to Central Ohio Eye and it's doctors all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance or authorized third party.

DATE_____ **SIGNATURE**_____

PATIENT ACKNOWLEDGE OF RECEIPT OF PRIVACY NOTICE

I, _____[**Print Name of Patient**], acknowledge that I received a copy of the Central Ohio Eye Physicians and Surgeons Inc., HIPAA Notice of Privacy Practices.

_____

Patient's Signature

_____

Date

Staff: If the patient did not acknowledge receipt of Privacy Notice above, you must document below your efforts to obtain the patient's acknowledgement and the reason why it was not obtained:

_____

_____

_____

CENTRAL OHIO EYE PHYSICIANS AND SURGEONS
PATIENT FINANCIAL POLICY

We are committed to providing you with the best possible medical care; if you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1. Our office participates with a variety of insurance plans. It is your responsibility to:
    a. Bring your insurance card to every visit and make us aware of any changes in your coverage.
    b. Be prepared to pay your co-pay at each visit. Payment can be made by cash, check, or credit card (Visa, MasterCard, Discover, or American Express). We are required by your insurer to collect this payment.
    c. For medical care not covered under your insurance, payment in full is due at the time of the visit.
2. If you have any insurance that we do not participate in, our office is happy to file the claim upon request, however, payment in full is expected at the time of service.
3. Referrals: It is your responsibility to bring any required referral for treatment at, or prior to, the visit. If you do not have the referral, your visit may be rescheduled in non-emergency visits, or you may be financially responsible.
4. If the patient is a minor (under age 18), the parent or guardian must sign below. The parent, guardian, or unaccompanied minor is responsible for any payment due at the time of service, bringing the necessary referrals and insurance card. If parent is responsible for any bills, we will ultimately rely upon the parent who brought the child to the office as being financially responsible.
5. If you have questions about your insurance, we are happy to help you. Specific coverage issues, however, should be directed to your insurance company's member services department (the number is on your insurance card).
6. If you fail to make payment in full for the services that are rendered to you, your outstanding balance may be forwarded for collection. You will be responsible for the fees assessed by the collection agency.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to our billing department at 614-224-4297. Please sign that you have read and agree to this Financial Policy.

Signature of Patient or Responsible Party Date

Signature of Co-Responsible Party Date