PATIENT INFORMATION

LAST NAME_____FIRST NAME_____MI_____

I PREFER TO BE CALLED_____ MALE/FEMALE DATE OF BIRTH_____

PRIMARY LANGUAGE_____RACE_____ETHNICITY_____

SOCIAL SECURITY _____DRIVERS LICENSE #_____ST_____

MAILING ADDRESS_____
Street or PO Box City State Zip

STREET ADDRESS_____
If different from mailing

HOME PHONE_____CELL PHONE_____

WORK PHONE_____EMAIL ADDRESS_____

PRIMARY DOCTOR_____
Name and number

EMERGENCY CONTACT_____
Name and number

WHO REFERRED YOU TO OUR OFFICE? _____
(Name of family physician, internist, optometrist, friend, yellow pages, etc.)

PATIENT INSURANCE INFORMATION

In order to insure accurate insurance information, we require your current insurance cards to scan

PRIMARY VISION INSURANCE _____POLICY #_____

POLICY HOLDER NAME _____POLICY HOLDER DOB _____

PRIMARY VISION INSURANCE _____POLICY #_____

POLICY HOLDER NAME _____POLICY HOLDER DOB _____

SECONDARY HEALTH INSURANCE_____POLICY #_____

POLICY HOLDER NAME_____POLICY HOLDER DOB_____

PERSON RESPONSIBLE FOR PATIENT

NAME_____DOB_____SS_____

MAILING ADDRESS_____
Street or PO Box City State Zip

HOME PHONE #_____CELL #_____WORK #_____

SIGNATURE OF RESPONSIBLE PARTY _____

Health History Questionnaire

Patients Name_____ Today's Date _____

What is the reason for your visit today?_____

Do you wear glasses? ☐yes ☐no If yes, how old are your current glasses?_____
Do you wear contact lenses? ☐yes ☐no If yes, how old is your CL prescription?_____
How many hours/day to you wear them? _____
How many hours per day do you spend on the computer each day? _____
Currently experiencing problems with: ☐Distance Vision ☐Near Vision ☐Dry Eye
What hobbies and sports do you participate in? _____

Do you currently have any of these vision symptoms?
(check all that apply)

Eye pain	☐ yes	☐ no
Blurry vision	☐ yes	☐ no
Double vision	☐ yes	☐ no
Frequent headaches	☐ yes	☐ no
Flashes of light	☐ yes	☐ no
Floaters	☐ yes	☐ no
Light sensitivity	☐ yes	☐ no
Glare/halos	☐ yes	☐ no
Redness	☐ yes	☐ no
Itching	☐ yes	☐ no
Burning	☐ yes	☐ no
Dryness	☐ yes	☐ no
Excessive tearing	☐ yes	☐ no
Foreign body sensation	☐ yes	☐ no
Gritty sensation	☐ yes	☐ no

Other: _____

Have you ever been diagnosed with any of the following **EYE** conditions?

☐ **NONE**
☐ Glaucoma ☐ Macular Degeneration
☐ Cataracts ☐ Retinal tear/detachment
☐ Lazy eye (amblyopia) ☐ Inflammation/Iritis
☐ Dry eye syndrome ☐ Ocular allergies
☐ Cataract surgery ☐ LASIK/RK surgery
☐ Serious eye injury
☐ Other: _____

Which **EYE** medications do you currently take?

☐ **NONE** ☐ Artificial Tears

Medication Name	Dose
_____	_____
_____	_____

MEDICAL HISTORY

Have you ever been diagnosed with any of the following?

☐ **NONE**
☐ High Blood Pressure ☐ Diabetes
☐ Heart Attack ☐ By-pass
☐ Stroke ☐ Thyroid Disease
☐ Bell's Palsy ☐ Migraine Headaches
☐ Sjogren's Syndrome ☐ Seasonal Allergies
☐ Other: _____

☐ High Cholesterol ☐ Heart Disease
☐ COPD ☐ Asthma
☐ Inflammatory Bowel Disease ☐ Crohn's Disease
☐ Osteoarthritis ☐ Rheumatoid Arthritis
☐ Multiple Sclerosis ☐ Cancer

Which medications do you currently take?
(prescription and non-prescription)

☐ **NONE**

Medication Name	Dose
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(request additional page if needed)

Do you have any allergies to medication?

☐**NONE** Reaction?

_____ _____
_____ _____

Have you ever been hospitalized or had surgery?

☐NO ☐ YES (if yes please explain) Date

_____ _____
_____ _____

Are you currently pregnant?

☐No ☐ Yes Nursing? ☐ No ☐ Yes

FAMILY MEDICAL HISTORY:

Has anyone in your family been diagnosed with any of the following conditions? If yes, please indicate relation.

	Relation:		Relation:
☐ Glaucoma	_____	☐ High Blood Pressure	_____
☐ Macular Degeneration	_____	☐ Diabetes	_____
☐ Cataract	_____	☐ High Cholesterol	_____
☐ Crossed Eyes	_____	☐ Heart Disease	_____
☐ Blindness	_____	☐ Stroke	_____
☐ Retinal Detachment	_____	☐ Thyroid Disease	_____
☐ Other: _____	_____	☐ Cancer	_____

REVIEW OF SYSTEMS (check only if you have these symptoms **TODAY**)

GENERAL	EAR, NOSE, THROAT	CARDIOVASCULAR	RESPIRATORY	GASTROINTESTINAL
☐NONE	☐NONE	☐NONE	☐NONE	☐NONE
☐Anorexia	☐Decreased Hearing	☐Chest Pain	☐Cough	☐Abdominal Pain
☐Fever	☐Sinus Problems	☐Palpitations	☐Shortness of Breath	☐Diarrhea
☐Weight Loss	☐Sore Throat	☐Peripheral Edema	☐Wheezing	☐Nausea
☐Chills	☐Pain w/ Swallowing			☐Constipation
☐Malaise	☐Ear Pain			☐Vomiting
☐Fatigue	☐Nose Bleeds			
☐Sweats	☐Vertigo			
MUSCULOSKELETAL	**SKIN**	**NEUROLOGICAL**	**ALLERGY**	**REPRODUCTIVE**
☐NONE	☐NONE	☐NONE	☐NONE	☐NONE
☐Joint Pain	☐Dryness	☐Dizziness	☐Seasonal Allergies	☐Irregular Cycles
☐Joint Swelling	☐Acne	☐Seizures	☐Food Allergies	☐Pregnant
☐Muscle Weakness	☐Itching	☐Dementia	☐Itching	☐Menopause
☐Back Pain	☐Rash	☐Tremors		
	☐Suspicious Lesion	☐Headaches		

SOCIAL HISTORY:

Use of Alcohol: ☐Never ☐Rarely ☐Moderately ☐Daily: ___drinks/day

Use of Tobacco: ☐Never ☐Previously, but not in ____ years ☐Yes: ____packs/day

Due to new quality reporting guidelines mandated by the government to improve continuity of care, we are required to ask the following questions:

Preferred Language:
- ☐ English
- ☐ Spanish
- ☐ Other_____

Race:
- ☐ American Indian
- ☐ Asian
- ☐ African American
- ☐ Caucasian
- ☐ Declined
- ☐ Other_____

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Declined

Have you received a flu shot this year?
☐Yes ☐No

Height: _____ft _____in

Weight: _____lbs

Patient/Legal Guardian/Authorized Person Signature X_____ Date_____

Lifetime Signature on File Assignment of Benefits, Financial Agreement. We are committed to providing you with the highest level of service and quality care. We expect, in turn, that you have the same commitment to your financial responsibility to us.

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to the **Eye Care Clinic & Optical, LLC (collectively referred to as ECCO)** for services furnished me by ECCO. I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. Coinsurance and deductible are based upon the final determination of the Medicare Carrier and are my responsibility. **MEDICARE ADVANTAGE PLANS:** I agree to provide appropriate information regarding my Medicare Advantage Plan to ECCO as this may affect coverage for services provided. If I fail to provide accurate and timely information to ECCO, I agree to be fully responsible for payment.

2. SUPPLEMENTAL INSURANCE: With current information, ECCO will file my supplemental insurance claim on my behalf. My signature below authorizes release of the information to the insurance company. I request that payment of authorized secondary insurance benefits be made on my behalf to ECCO. If my supplemental insurance plan pays me directly, I agree to remit said payment immediately to ECCO.

3. RELEASE OF INFORMATION: ECCO may disclose all or any part of my medical record and /or financial ledger to any person or corporation which is or may be liable or under contract to ECCO for reimbursement for services rendered, and to any health care provider for continued patient care. A copy of this authorization may be used in place of the original.

4. OTHER INSURANCE: ECCO participates with most major insurance plans and will make a reasonable effort to notify me if ECCO has no contract, expressed or implied, with my particular insurance plan. Notification may be verbal or by signage.. However, it is ultimately my responsibility to understand my insurance plan's coverage, benefits and limitations. I agree to be responsible for all items or services rendered by ECCO regardless of insurance coverage, and I accept full financial responsibility if incorrect or untimely insurance information is given by me to ECCO.

5. NON-COVERED SERVICES: I UNDERSTAND THAT ECCO'S contracts with insurance plans related only to items and services which are covered by the insurance plans, and that ECCO does not determine what defines a covered benefit of my insurance company and cannot make any guarantees about coverage. That determination is made only by my insurance plan after the claim is received. Accordingly, the undersigned accepts full financial responsibility for all items or services which are determined by the health care service plans to be non-covered. Examples of non-covered items may include services considered to be routine, cosmetic, preexisting or experimental, and treatment or test not recognized by the health care service plan.

6. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by ECCO, I will pay my account at the time of service is rendered or will make financial arrangements satisfactory to ECCO for payment. Copays not paid at time of service are subject to a $10.00 billing fee. Repeat statements are subject to a $10.00 billing fee. **MINOR CHILDREN:** ECCO is not party to any divorce or custody arrangement, therefore the parent accompanying the minor child is responsible for payment. **COLLECTIONS:** If an account is sent to an agency for collection, I agree to pay all collection expenses and reasonable attorney's fees as established by the court. I understand and agree to my account is placed for collection, I will be charged a delinquent account fee based on my account fee based on my account balance as follows: for balances up to $100.00, the fee added is $25.00. From $101.00 to $500.00, the fee added is $50.00. From $501.00 to $1000.00, the fee added is $75.00. For balances over $1001.00, the fee added is $100.00 Delinquent account fees are not negotiable. Non-payment of accounts may result in termination from the practice. Account disputes must be received within 60 days of first statement date. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to ECCO.

7. NO SHOW POLICY: ECCO REQUIRES A 24 HOUR NOTICE FOR CANCELLATIONS OR A $25.00 FEE WILL BE BILLED TO THE PATIENT.

IT IS UNDESTOOD THAT THE UNDERSIGNED AND/OR THE PATIETN ARE PRIMARILY RESPONSIBLE FOR THE PAYMENT OF MY BILL REGARDLESS OF INSURANCE COVERAGE.

_____

Beneficiary or Authorized/Responsible Party Signature Date

Right to Notice
As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPPA), Eye Care Clinic & Optical can use your protected health information for treatment, payment and health care operations.
a)Treatment - We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
b)Payment - We may use and disclose your health information to obtain payment for services we provide you.
c)Health care operations - We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization
Most uses and disclosures that do not fall under treatment, payment, health care operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

Emergency Situations
In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your healthcare.

Marketing
We will not use your health information for marketing communications without your written authorization.

Required by Law
We may also use or disclose your health information when we are required to do so by law.

Abuse or Neglect
We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health or safety.

National Security
We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

Appointment Reminders
We may use or disclose your health information to provide you with appointment reminders via phone, e-mail or letter.

Your Rights as a Patient

You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or health care operations.

-You have the right to receive confidential communications regarding your protected health information.
-You have the right to inspect and copy your protected health information.
-You have the right to amend your protected health information.
-You have the right to receive an account of disclosures of your protected health information.
-You have the right to a paper copy of the notice of privacy practices.

Legal Requirements

Eye Care Clinic & Optical is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are posted to this site, or are available within our office.

Complaints

If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint.

Contact Information

For further information about Eye Care Clinic & Optical's privacy policies, please contact us at the following address or phone number:

Eye Care Clinic & Optical, LLC
6228 Yellowstone Rd
Cheyenne, WY 82009
(307) 778-2771