VILLAGE OPTICAL

# PATIENT REGISTRATION

## PATIENT INFORMATION

**TODAY'S DATE:** _____

Name: _____ Date of Birth: _____

Address: _____

_____

Social Security Number: _____ Occupation: _____

Gender: ☐ Male ☐ Female ☐ Other Preferred _____

Phone: _____ Email: _____

I would like to receive automated: ☐ Text Messages ☐ Phone Calls

Are we able to leave a voicemail?: ☐ Yes ☐ No

## MEDICAL INSURANCE

Policyholder's Name: _____

Date of Birth: _____ Relationship: _____

Insurance: _____ ID Number: _____

Does the insurance require referrals? ☐ Yes ☐ No

If yes, it is your responsibility to obtain a referral for any medical care prior to the exam. _____
Initials

## VISION INSURANCE

Policyholder's Name: _____

Date of Birth: _____ Relationship: _____

Last 4 digits of policyholder's Social Security Number: _____

☐ EyeMed ☐ VBA ☐VSP ☐Davis Vision

## ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s) have insurance coverage as listed above and assign directly to Village Optical all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Village Optical and the doctors may use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. Medicare is a medical insurance and unfortunately Medicare does not cover the refraction fee. If the doctor performs a refraction, CPT code 92013 or 92015 during the exam, it is the patient's responsibility for the payment.

_____
Signature of patient, parent, guardian or personal representative

_____
Printed name of patient, parent, guardian or personal representative

_____ _____
Relationship Date

**NAME:** _____

## PERSONAL HISTORY

What brings you in today?: _____

Specific Concerns: _____

Do you wear glasses?: ☐ Yes ☐ No If yes, what type?: _____

Do you wear contact lenses?: ☐ Yes ☐ No If yes, name of contacts: _____

Are your contacts comfortable?: ☐ Yes ☐ No

How often do you change them?: _____

Primary Care Doctor: _____

## OCULAR HEALTH

Have you ever been diagnosed with any of the following?:

☐ Amblyopia (lazy eye)
☐ Blepharitis/MGP
☐ Cataracts
☐ Dry Eye Syndrome
☐ Floaters
☐ Fuchs Corneal Dystrophy
☐ Glaucoma
☐ Hyphema
☐ Keratoconus
☐ Macular Degeneration
☐ Optic Nerve Disease
☐ Double Vision
☐ Pituitary Adenoma
☐ Refractive Surgery
type: _____
☐ Retinal Detachment
☐ Uvieitis/Iritis
☐ Other: _____

## GENERAL HEALTH

Are you being treated for any of the following?:

☐ Autoimmune Disorder
Type: _____
☐ Cancer
Type: _____
☐ Diabetes
Type: _____
☐ Heart Disease
☐ High Blood Pressure
☐ IBS/Colitis/Chron's
☐ Kidney Problems
☐ Liver Disease
☐ Lung Disorders
☐ Rosacea
☐ Thyroid Dysfunction
☐ Other: _____
_____
_____
_____

Do you have a history of:

☐ Concussion ☐ Traumatic Brain Injury

List any surgeries: _____

Are you taking any medications?: ☐ Yes ☐ No

If yes, please list or provide a copy: _____

_____

Any allergies to medications?: _____

Are you pregnant or nursing?: ☐ Yes ☐ No

**NAME:** _____

## FAMILY HISTORY

Does any family member have the following?:

☐ Cataracts ☐ Glaucoma ☐ Optic Nerve Disease
☐ Dry Eye Syndrome ☐ Keratoconus ☐ Pituitary Adenoma
☐ Fuchs Corneal Dystrophy ☐ Macular Degeneration ☐ Retinal Detachment
☐ Other: _____

Is anyone in your immediate family being treated for the following?:

☐ Autoimmune Disorder ☐ Diabetes ☐ Kidney Problems
Type: _____ Type: _____ ☐ Liver Disease
☐ Cancer ☐ Heart Disease ☐ Lung Disorders
Type: _____ ☐ High Blood Pressure ☐ Thyroid Dysfunction
☐ Other: _____

## SOCIAL HISTORY

Do you use tobacco products?: ☐ Yes ☐ No
If yes, type: _____ Amount: _____ Length of Time: _____

Do you drink alcohol?: ☐ Yes ☐ No
If yes, type: _____ Amount: _____ Length of Time: _____

Print Patient Name

# RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The Notice of Privacy Practices that has been made available to you describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this form. As described in this Notice, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, termination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our Notice of Privacy Practices. Even though an insurance plan may be in effect insuring you for services rendered by our office, a final determination of benefits can only be made after a claim has been processed. As a courtesy to you, Elder Eye Care Group is hereby authorized to submit a claim to your insurance carrier (assuming we participate in your plan); however, you agree to be responsible for any fees left unpaid by the carrier. In the event that an account requires settlement through an outside collection agency, you will be responsible for all costs associated with the collection of the account, including legal fees, if any. When you sign this document, you signify that you agree that we can, and will, use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have been offered a copy of our Notice of Privacy Practices.

You have the right to request us to restrict the use and disclosure of your information, but as described in our Notice of Privacy Practices, we are not required by law to agree to these requested restrictions. If we do agree, however, the restrictions are binding on us and we will make every effort to honor all reasonable requests. Our Notice of Privacy Practices describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for the purposes of treatment, payment and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from Elder Eye Care Group DBA Village Optical.

Signature

Date

If signing as a legal personal representative of the patient, describe the relationship to the patient and the sources of authority to sign this form.

Relationship to Patient

Print Name

I authorize Elder Eye Care Group DBA Village Optical to disclose my personal healthcare information to the following people:

Name

Relationship

Name

Relationship

Name

Relationship

# ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE AND MEMBER FINANCIAL LIABILITY ACKNOWLEDGMENT FORM

## MEDICAL INSURANCES AND REFRACTIONS

When using your medical insurance for an office visit (eg; Medicare, IBC, Aetna), your medical insurance does not cover the cost of the refraction portion of an eye exam. This service measures your prescription for eyeglasses and/or contact lenses. The fee is $45 for a phoropter refraction and $65 for a low vision refraction which is an out of pocket cost.

## EYEGLASSES FOR POST-OPERATIVE CATARACT PATIENTS

Medicare and other medical insurances have an allotment amount towards one pair of eyeglasses after cataract surgery. Medicare covers a fixed amount towards frame selection and pays various amounts toward each type of lens (single vision, bifocal, trifocal). However, Medicare does not pay for upgrades such as progressive or transition lenses. The additional cost of these upgrades is an out of pocket expense for you.

If you have a secondary or supplemental plan associated with Medicare, please present both cards at the time of service. Please be aware that it is the patient responsibility to notify Medicare directly if you have a secondary or supplemental plan that Medicare needs to bill.

## DEDUCTIBLE AND/OR CO-INSURANCE PLANS

Many insurance plans are subject to a deductible and/or co-insurance. If the deductible has not been met or if you have a co-insurance plan, you will receive an additional bill after your insurance processes the claim. This may take up to a month to process. These monies are separate from specialist copays which are collected at the time of service.

## REFERRALS

For major medical insurances that require a referral, it is the patient responsibility to ensure the referral is requested through your primary care physician's office. Our office will call your primary for you under certain circumstances as a courtesy, but we request that the patient follow up with the primary care physician to ensure a referral was processed for the correct date of service. If a referral is not obtained, the patient will be responsible for the entire cost.

## CONTACT LENS PROFESSIONAL FITTING

This service is not covered by a majority of insurance plans. This is separate from the routine eye exam and is required every year by Pennsylvania State law to renew the contact lens prescription. The cost varies depending on the level of fitting.

## TESTING

If you are having additional testing (i.e. visual field, OCT, gonioscopy, photos, etc.) or are in for a major medical issue separate from your routine eye exam, the claim will be sent through your major medical insurance carrier. These are often subject to copays, deductibles and/or co-insurance.

I, _____. hereby agree to be financially liable for and to pay the provider the amount of the charges for certain healthcare services, which representatives of the provider have explained to me may not be covered by my specific insurance plan or may have additional costs. These charges will be submitted to my insurance company and if they do not pay for the services, I will then receive a bill from the provider.

_____ _____

Patient Signature (or Patient/Guardian) Date