Anaheim Eye

PATIENT DEMOGRAPHIC INFORMATION

DATE: _____

NAME (First, Middle, Last)	**EMAIL**	
ADDRESS (Include Apt. # or Box #)	**CITY, STATE, ZIP CODE**	**PHONE**
BIRTH DATE (Mo./Day/Year)	**AGE**	**SEX** ☐ M ☐ F
EMPLOYER	**WORK PHONE**	**SOCIAL SECURITY #**
MARITAL STATUS ☐ Married ☐ Divorced ☐ Single ☐ Widowed		
SPOUSE'S NAME	**SPOUSE'S EMPLOYER**	**SPOUSE'S WORK PHONE**
IF MINOR, PARENT'S NAME	**DRIVER'S LICENSE** (If minor, parent's DL #)	**IF MINOR, PARENT'S SOC. SEC. #**
IN CASE OF EMERGENCY - NEAREST FRIEND OR RELATIVE	**RELATIONSHIP**	**PHONE**

WHO RECOMMENDED US?

☐ Friend or Relative _____ ☐ Doctor _____

☐ Google ☐ Optometrist _____

☐ Facebook ☐ Other (specify) _____

NAME OF PRIMARY INSURED	**NAME OF SECONDARY INSURED**
SOCIAL SECURITY NUMBER OF PRIMARY INSURED	**SOCIAL SECURITY NUMBER OF SECONDARY INSURED**
BIRTH DATE OF PRIMARY INSURED	**BIRTH DATE OF SECONDARY INSURED**
ALLERGIES OR REACTIONS TO MEDICINES	
NAME OF FAMILY DOCTOR	**PHONE**

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

2. All charges for non-covered services or items must be paid in full at time of visit or upon delivery.

3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.

4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNED (Patient or Parent if Minor) _____ **DATE** _____

FOR OFFICE USE ONLY:	**METHOD OF PAYMENT**	**PAYOR CODE**	**M.D.**	**INTERVIEWER**
	☐ Cash ☐ Check ☐ Credit Card			

Anaheim Eye

PERSONAL QUESTIONNAIRE

Name: _____ **Date:** _____

Age: _____ **Date of Birth:** _____ **Date of last eye exam:** _____

PAST MEDICAL HISTORY

List all major illnesses: _____

List current medications: _____

List all surgeries (including eye surgery): _____

Do you have any allergies to medications? ☐ No ☐ Yes

If "yes," name drug(s): _____

FAMILY HISTORY: Has anyone in your family had any of the following?

	NO	YES	WHO?		NO	YES	WHO?
Macular Degeneration Retinal Disease	☐	☐		Keratoconus	☐	☐	
Cataract	☐	☐		Crossed/Lazy Eye	☐	☐	
Glaucoma	☐	☐		Blindness	☐	☐	
				Neurologic Disease	☐	☐	

SYSTEM REVIEW: Do you currently have any problems in the following areas?

	NO	YES	DESCRIBE THE PROBLEM
Eyes	☐	☐	
Ears, Nose, Throat	☐	☐	
Heart	☐	☐	
Respiratory (Asthma, etc.)	☐	☐	
Stomach, GI tract	☐	☐	
Urinary System	☐	☐	
Muscles, Bones, Joints	☐	☐	
Neurologic Problem	☐	☐	
Skin	☐	☐	
Psychiatric	☐	☐	
Endocrine (Diabetes), Thyroid	☐	☐	
Blood, Cholesterol	☐	☐	
Allergy, Immunologic	☐	☐	

SOCIAL HISTORY

Current/Previous Occupation: _____

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Do you drive?: ☐ Yes ☐ No

Do you have any visual difficulty driving at night? ☐ Yes ☐ No

Do you drink alcohol? ☐ No ☐ Yes

if "yes": ☐ Occasional ☐ 1/day ☐ 2-3/day ☐ 4+/day

Do you currently smoke? ☐ No ☐ Yes

if "yes": ☐ Occasional ☐ 1/2pk/day ☐ 1pk/day ☐ 1+ pks/day

Do you have any interest in Laser Vision Correction to reduce your dependence on eyeglasses or contact lenses? ☐ Yes ☐ No

HISTORY REVIEWED ☐ No Changes

Physicians Signature: _____ **Date:** _____

Anaheim Eye

FINANCIAL AGREEMENT

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Thank you for choosing Anaheim Eye as your eye care provider. The following is our Financial Policy, which will help you with your concerns regarding our billing and payment procedures.

PAYMENT FOR SERVICES: Payment is due at the time service is rendered. We accept cash, checks, money orders, debit cards, MasterCard, Visa, and Discover. **We will submit an insurance claim on your behalf**. If your insurance carrier is not contracted with our practice, we will courtesy bill them with the understanding that **any balance remaining after insurance payment, is your responsibility and due within 30 days of your first billing statement**.

Initials _____

CO-PAY: If you have co-pay, it will be collected at the time of service. Please note that we do not submit co-pays to a secondary insurance carrier. Should you like, we can give you the appropriate information to do this on your own.

Initials _____

You are responsible for knowing the policies and provisions of your insurance plan; i.e., which services are covered, whether or not we are a participating provider for your insurance, or whether or not you have coverage. Ultimately, you are responsible for payment of all services rendered at Anaheim Eye. Any billed balances are due within 30 days of the statement date.

Initials _____

If you have an HMO Insurance, YOU ARE RESPONSIBLE for verifying that referrals/ authorizations are obtained from your Primary Care Physician and / or insurance carrier. Patients are responsible for all deductible balances, co-insurance fees, and non-covered amounts at the time of service. Any billed balances are due within 30 days of the statement date.

Initials _____

Anaheim Eye

FINANCIAL AGREEMENT

IF YOUR INSURANCE COMPANY DOES NOT PAY, IN FULL, WITHIN 60 DAYS OF SERVICE, CHARGES WILL THEN BE TRANSFERRED TO YOU. WE REQUIRE YOU TO PAY THE BALANCE DUE EVEN IF YOUR INSURANCE CARRIER EVENTUALLY PAYS YOUR CLAIM. SHOULD THAT HAPPEN, A REFUND WILL BE MAILED TO YOU.

Initials _____

Interest on past due balances will accrue at a rate of 1.5% monthly. There will be a $25.00 fee for all returned check items. Should your account become delinquent, it will be referred to a **collection agency**, and you shall be financially responsible for the costs of collection and/or legal fees. Collection costs are calculated by adding to the principle, the greater of $25 or an amount 35% in excess of the balance owed.

Medicare and other medical insurance carriers will not cover testing your prescription for eye glasses or contact lenses. This test determines whether your vision can be improved with glasses and is needed to dispense glasses or obtain approval for any surgery. Therefore, be aware that there is a **$65.00 fee** for the refraction testing due at the time services are rendered.

Initials _____

The following **appointment cancellation policy** will be **STRICTLY ENFORCED**:

- Should you make an appointment with our office and miss that appointment without a prior 24 hour cancellation notice, you will be charged the amount of **$75.00** with the only exception of a medical excuse with a valid doctor's note.

- Should you schedule surgery and cancel your surgical appointment less than 1 week prior to your surgical date, you will be charged the amount of **$350.00**.

Initials _____

I have fully read, understand, and agree to adhere to all of the elements of this financial agreement.

Print Full Name: _____

Signature: _____ **Date:** _____

Anaheim Eye

AUTHORIZATION OF PAYMENT

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I request that payment of authorized Medicare/ or any third party benefits be made to Anaheim Eye on my behalf for any services rendered to me.

I authorize any holder of medical information about me to release to the Center for Medicare/ Medicaid Services and its agents or any third party payor any information to determine these benefits or the benefits payable for related service.

Printed Name of Patient/Responsible Party

Signature of Patient/Responsible Party

Date

Anaheim Eye

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Anaheim Eye

1211 W. La Palma Avenue, Suite 201 • Anaheim, CA 92801
Tel. 714.533.2020 • Fax 714.533.9920

I understand that, under the Health Insurance Portibility & Accountability Act of 1196 ("HIPPA"), I have certain rights to privacy regarding my protected health inforrhacion. I understand that this information can and will be used to:

• Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.

• Conduct normal health care operations such as quality assessments and physician certifications.

• Obtain payment from third party payers.

I have received, read, and understand your "Notice of Privacy Practices" containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the "Notice of Privacy Practices."

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree with my requested restrictions but even if you do not agree, you are bound to abide by such restrictions.

Patient Name _____

Patient Representative _____

Signature _____

Date _____

Office Use Only

I attempted to obtain the signature of the patient or patients representative acknowledging the receipt of the "Notice of Privacy Policies", but was unable to do so as documented below:

Date: **Initials:** **Reason:**