Welcome to The Eye Center

Doctor: _____

We would appreciate your help answering the following questions:

How did you hear about our practice?

___Our website (www.theeyecenters.net)

___ Referred by another doctor

If referred, please provide the name of the doctor. _____

___ Referred by my insurance company

If referred, please provide the name of your insurance company. _____

___ Family member/friend

___ Yellow Pages

___ Google Search

___ Other internet search engine.

Please identify the search engine. _____

___ Facebook

___ Other

Please Specify _____

Did you know that Dr. David Hessert offers LASIK eye surgery?

____ Yes ____ No

PATIENT INFORMATION

Patient's Last Name_____First_____MI_____

(Please Print) Preferred Name _____

Social Security # _____Age _____ Sex_____ Race_____ Birthdate_____

Address _____ Marital Status: M S D W

City _____ State _____ Zip _____ Home Phone #_____

Cell Phone # _____ Work Phone # _____

E-Mail _____

HIPAA RELEASE

May we leave detailed personal health information on your contact phone number voicemail?
This information may include pathology results, lab results, appointments, etc.

Home Phone: Yes( ) No( ) Cell Phone: Yes( ) No( ) Business Phone: Yes( ) No( )

Who may we discuss your health information with?

No one other than self( ) Spouse( ) Parent( ) Voicemail( ) Other( )_____

Name and Address of Employer _____

_____

Name of Spouse or Parent/Guardian _____
(if patient is under 18 yrs of age)

Spouse Work Phone# _____ Spouse Cell Phone# _____

Family Doctor _____ Name of Clinic _____

Emergency Contact _____ Relationship _____ Phone # _____
(Friend or Relative not living with you)

I HEREBY ACKNOWLEDGE HAVING READ OR RECEIVED THE NOTICE OF INFORMATION PRACTICES.

I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PROVIDER WHO ACCEPTS ASSIGNMENT. I UNDERSTAND ANY COPAYS AND NON-COVERED SERVICES ARE TO BE PAID AT THE TIME OF SERVICE.

I WILL NOTIFY THE EYE CENTER WITHIN 24 HOURS OF MY APPOINTMENT IN THE EVENT THAT I AM UNABLE TO ATTEND; FAILURE TO DO SO MAY RESULT IN A $30.00 CANCELATION FEE.

Patient's Signature: _____ **Date:** _____
(Parent or Guardian if under 18)

INSURANCE INFORMATION

PRIMARY INSURANCE _____ POLICY # _____GROUP #_____

Insured Name _____ Insured DOB _____

Insured Address _____ Insured SS# _____

Insured Cell Ph# _____ Insured Home Ph# _____ Insured Work Ph# _____

Insured Employer _____ Insured Relationship to Patient _____

SECONDARY INSURANCE _____POLICY # _____GROUP #_____

Insured Name _____ Insured DOB _____

Insured Address _____ Insured SS# _____

Insured Cell Ph# _____ Insured Home Ph# _____ Insured Work Ph# _____

Insured Employer _____ Insured Relationship to Patient _____

GUARANTOR _____ Guarantor DOB _____
(if different from patient or insured)

Guarantor Name _____ Guarantor DOB _____

Guarantor Address _____ Guarantor SS# _____

Guarantor Cell Ph# _____ Guarantor Home Ph# _____ Guarantor Work Ph#_____

Insured Employer _____ Insured Relationship to Patient _____

EYE PATIENT HEALTH HISTORY

Last Name _____ First _____ MI ___ Preferred Name_____

Race _____ Date of Birth _____ Pharmacy (Include Location) _____

Primary Care Physician (Family Doctor) _____ Referring Physician _____

Are you taking any kind of MEDICATION now? (This includes prescription, over-the-counter, or herbal medications)
☐ No ☐ Yes If yes, please list below.

NAME, DOSE, and HOW OFTEN	Problem being Treated	Date Prescribed	Prescribing Doctor

Are you ALLERGIC to any medication? ☐ No ☐ Yes (If yes, please list below)

Name of Medication	Type of Reaction

PAST MEDICAL HISTORY

Have you ever been diagnosed with a major health problem? (Ex: Diabetes, Asthma, Glaucoma) ☐ No ☐ Yes (List)

_____ _____

_____ _____

Have you ever had an EYE INJURY or EYE SURGERY? ☐ No ☐ Yes (List)

_____ _____

_____ _____

FAMILY HISTORY

Are there any EYE PROBLEMS that seem to run in your family such as Glaucoma? ☐ No ☐ Yes (List)

_____ _____

_____ _____

SOCIAL HISTORY

What is your occupation? _____ ☐ Check here if you are retired Marital Status _____

Living setting: ☐ Alone ☐ Spouse ☐ Children ☐ Parent(s) ☐ Nursing Home/Assisted Living ☐ Other _____

REVIEW OF SYSTEMS List any problems you have or have had recently in the following areas.

General Health (Fever, weight loss or gain, problems sleeping, fatigue, weakness, etc.) No Yes

_____ _____

_____ _____

Eye problems that have not been corrected by glasses (vision loss, double vision, blurred vision, etc.) ☐ No ☐ Yes

_____ _____

_____ _____

The Eye Center of Oak Ridge Financial Policy

1. ***INSURANCE*** We participate in most primary insurance plans, including Medicare. We will also file any secondary insurance as a courtesy. *Knowing and understanding YOUR insurance benefits is YOUR responsibility.* If you are not insured by a plan we are in contract with, payment in full is expected at each visit. If you are insured by a plan we are in contract with but do not have an up to date insurance card, payment in full is expected.
2. ***CO-PAYMENTS AND DEDUCTIBLES*** All co-payments and deductibles must be paid at the time of service. This arrangement is part of the contract with your insurance company.
3. ***CO-INSURANCE*** After your insurance processes the claims, you will be billed for any co-insurance or patient responsibility according to your insurance contract.
4. ***REFERRALS*** Some insurers require referrals for services. It is YOUR responsibility to obtain referrals. If you did not obtain a referral prior to services, you will be responsible for the balance.
5. ***CLAIMS SUBMISSION*** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. IT IS YOUR RESPONSIBILITY TO COMPLY WITH THEIR REQUEST. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefit is a contract between you and your insurance company. We are not a party to that contract.
6. ***NON-PAYMENT*** If your account is over 90 days past due, we will turn your account over to our collection agency.
7. ***NON-COVERED SERVICES*** Please be aware that some and perhaps all of the services you receive may be non-covered or considered not reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit.

Please sign below to indicate that you have read and you fully understand our Financial Policy.

_____

Patient Name (Please print)

_____ _____

Patient or Guarantor Signature **Date**

Notice of Non-Covered Services

REFRACTION (Helps determine if you have a medical problem or need glasses)

As part of your examination, it is necessary for us to determine your best corrected vision. This test is called a **refraction.** In some situations, it will be necessary for us to perform this measurement to fully evaluate your eye condition, even if you do not desire new glasses.

Medicare and most other medical insurance companies **will not** pay for this service, even though they often require it. You will be responsible for such services at the time of your examination.

REFRACTION FEE: $45

We will be happy to answer any questions you may have.

Signature: _____ Date: _____
(Patient or Parent/Legal Guardian)

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(Patient or Parent/Legal Guardian)

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(Patient or Parent/Legal Guardian)

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