PRECISION EYE
INSTITUTE

How did you hear about us?

(Please Circle one)

Google Ad

Google Search

Facebook Ad

Yellow Pages.com

Yelp

Insurance Company

Walk-In / Drove By

Doctor Referral: ____

Personal Referral: _______________________________________

Other:____

Please circle if interested in cosmetic product(s) shows below:

Patient Information

LAST NAME____FIRST:____________________________________ M.I. ________

DOB __________________ SS# (minimum last 4 for insurance) _____________________________

Cell #: ____ Home/Work #:______________________________________

ADDRESS ____

CITY _________________________________ STATE_________ZIP____________

SEX: M F MARITAL STATUS: S M W D ETHNIC ORIGIN: __________________

*EMAIL(Portal & Appointment Reminders)*____

ALTERNATE ADDRESS (SEASONAL RESIDENTS)____

CITY ____________________________________STATE_________ZIP_____________PHONE____________________________

EMERGENCY CONTACT

FIRST & LAST NAME ____

PHONE ___________________________________ RELATIONSHIP TO PATIENT______________________

WORK COMP PATIENTS ONLY:

EMPLOYER ____

EMPLOYER ADDRESS ____

EMPLOYER CITY _____________________________ STATE ______ ZIP _________ PHONE ___________________________

RESPONSIBLE PARTY (For minors or authorized signer for non-signing adult)

RELATIONSHIP TO PATIENT ____

LAST NAME ____FIRST NAME_______________________________________

ADDRESS ____

CITY ___________________________________STATE________ZIP___________PHONE____________________________

DOB ___________________ SS# _________________________________

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

SIGNATURE ____ DATE _____________________

Patient Name: ____

Pharmacy- Name & Location:____

Primary Care Doctor Name & City :____

Medical History: (Please Circle)

Anxiety Arthritis Asthma Cancer: Type____________________

CHRONIC Migraine COPD Diabetes; Type: __________ Insulin : Yes / No

Heart Attack Heart Disease Hepatitis; Type: _______

High Cholesterol High Blood Pressure HIV / AIDS Stroke

Thyroid Disease: Hypo Hyper

Other:____

Ocular History: (Please Circle)

Cataracts OR> Cataract Surgery ; Right: Date __________ Left: Date: ___________

Contacts/Glasses Corneal Disorder Dry or Watery Eyes Flashes / Floaters

Glaucoma LASIK <or> RK Macular Degeneration Narrow Angles

Other: ____

Family History of: Glaucoma Macular Degeneration

Current Rx or OTC Medications (We can copy list)

Name of Drug	Dosage & How Often

Allergies: (i.e. Latex, Sulfates, Penicillin, etc) ____

____

Social History:

Smoke Cigarettes or Cigars: Yes / No Drink Alcohol? Yes / No ____ Drinks/Day Do you drive? Yes / No

Signature: _______________________________________ Date: __________________

<u>OBTAINING A GLASSES PRESCRIPTION AT YOUR VISIT</u>

IMPORTANT Notice to our Patients:

In order for us to provide you with your most current glasses prescription, the technicians and physician will perform <u>specialty testing</u> know as refraction.

This service is <u>NOT</u> covered by ANY health/medical insurance as it is considered a routine vision service.

Because this service is performed for our patients' benefit, but not billable to health/medical insurances*<u>, there is a $30 fee that is payable upon receipt of your prescription~</u>*.

~You are not paying for the print-out of the prescription, but for the testing done by the technician and/or Doctor to generate a correct updated prescription.

If you request we bill your insurance and the charge is denied as a non-covered service/charge you are responsible for payment.

We do accept VSP and EYEMED vision plans, which cover this testing as part of a ROUTINE* eye exam ONLY.

You have the right to decline refraction testing at your visit,
but you will <u>NOT</u> be provided with a glasses prescription.

*ROUTINE eye exams do not provide testing for or treatment of any discovered or existing medical conditions. If you wish to be seen under your VISION plan (VSP/EYEMED) only, and a medical condition is discovered, an additional visit will be required in order to utilize the benefits of your health insurance for additional evaluation, testing, and to determine if treatment is required.

Please do not hesitate to ask our staff any questions you may have about this testing or policy.

By signing, you acknowledge you have read and understand your rights and responsibilities.

____

Name Signature Date

PATIENT PRIVACY NOTICE AND CONSENT

Our notice of privacy practices provides information about how we may use and disclose protected health information about you (HIPAA). This notice contains a patient rights section describing your rights under the law. You have the right to review our notice before signing the consent. The terms of our notice may change, at which time you will be provided with a revised copy, or may request an updated copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in relationship to your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient or representative/guardian understands that:

- Protected health information may be disclosed or used for treatment, payment, or health operations.
- The practice has a notice of privacy and that I have received this notice.
- The practice reserves the right to change the notice of privacy policies.
- I have the right to restrict the uses of their information but the practice does not have to agree with those restrictions.
- I may revoke this consent in writing at any time and all future disclosures will the cease
- The practice may provide or perform necessary and agreed upon condition treatment upon the execution of this consent

________________________________ _______________________________________ _____________

Print Name **Signature** **Date**

Patient Name____

FINANCIAL POLICY

- **<u>It is your responsibility to inform our office of any insurance, address, or telephone number changes.</u>**
- Our office sends monthly statements on all accounts with an outstanding balance to the address provided.
- Your account is to be kept current; accordingly, all self-pay charges, insurance co-payments, co-insurances and deductibles may be collected **at the time of service** when applicable.
- Payments may be made via Check, Cash, Care Credit, Visa, MasterCard, Amex or Discover.
- A returned check will result in a **$30.00** service fee and all future payments will be required in the form of cash or credit/debit card.

I have read, agree to, and understand the above policy: Signature ________________________________Date: ______

ASSIGNMENT OF MEDICARE / PARTICIPATING INSURANCE PLANS BENEFITS

(If you are Self-Pay/Un-Insured, Skip this section and go to bottom of page)

PRIMARY INSURANCE:____ Circle Applicable Vision Plan Below

SECONDARY INSURANCE: ____ **VSP** **EyeMed**

We will submit your claims, however we must emphasize that as medical providers, our relationship is with you, NOT your insurance company.

- **<u>It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be verified prior to your appointment, including any VISION plan you may have SEPARATE from your health insurance.</u>**
- **Not all services are covered benefits with all insurance plans.**
- **It is your responsibility to be aware of what services being provided to you are or are not a covered benefit under your individual insurance plan.**
- **You are responsible for any non-covered charges not payable by your insurance policy.**
- **We do not file third insurance claims, or reimbursement forms, only primary and secondary.**
- **Although filing your claims is a courtesy extended to you, all charges from the date when service is rendered are your responsibility.**

I authorize release of any medical information to the above insurance carrier(s) to determine benefits payable. I request that payment be made on my behalf to OREST M KRAJNYK MD PA/PRECISION EYE INSTITUTE for any services furnished to me. I understand any charges not payable by my participating insurance after verification will be my responsibility.

I have read, agree to, and understand the above policy: Signature ________________________________Date: ______

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<u>SELF PAY PATIENTS ONLY</u>: I understand and sign below as agreement that any charges for services rendered are my responsibility and are **payable at the time of service** unless prior arrangements are made.

Signature: ____ Date: ________________________