# Welcome to **Williamson Eyecare** your Vision Source

**Please complete the following forms in its entirety.**

Last Name___________________________________ First Name____________________________________ MI__________

Address________________________________________ City________________________ State_______ Zip______________

Date of Birth______________________ Age_______ Social Security #________________________ Marital Status______

Home Phone_________________________________________ Cell Phone_________________________________________

E-Mail ________________________________________________________________________________________________

**Please list BOTH vision and medical insurances and bring all insurance cards with you to your appointment.**

| **MEDICAL INSURANCE** | |
|---|---|
| **Ins. Co. Name:** | **Secondary Ins. Co. Name:** |
| **Insured's Name:** | **Insured's Name:** |
| **Identification #:** | **Identification #:** |
| **Group#:** | **Group#:** |
| **Insured's DOB:** | **Insured's DOB:** |
| **Patient Relation to insured:** | **Patient Relation to insured:** |
| **VISION INSURANCE** | |
| **Ins. Co. Name:** | **Insured's DOB:** |
| **Insured's Name:** | **Insured's SS#:** |
| **Identification #:** | **Patient Relationship to Insured:** |

**Primary Care Physician** ______________________________________________**Phone:**______________________________

**Please list any medications that you are currently taking below** (drug name and dosage)

________________________ ________________________ ________________________ ________________________

________________________ ________________________ ________________________ ________________________

**Drug Allergies**_________________________________________________________________________________________

**Consent of treatment: I hereby grant MY authorization and consent for treatment and procedures for myself and/or minor children and certify that no guarantee or assurance has been made as to the result which may be obtained.**

_______________________________________________________________ ________________________

**Signature of Patient or Legal Representative** **Date**

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## EYEGLASS HISTORY

Do you wear glasses? ___ Yes ___ No ___Part-time ___ Distance ___Near

Glasses Owned: ___ Single Vision ___Bi-focal ___Tri-focal ___Progressive ___Backup Glasses ___Sports Glasses ___ Other

Computer Used: ___Yes ___No Hours per day ____ Approximate distance from computer___________________

Do you have problems with glare? Yes ___ No ___

Do you have problems with night vision? Yes ___ No ___

Are you allergic to nickel (e.g.: jewelry or eyeglass frames discoloring your skin)? Yes ___ No ___

If you currently wear glasses, does your spare pair have the same prescription? Yes ___ No ___

Do you wear prescription or non-prescription sunglasses? Yes ___ No ___

Do your sunglasses have UV (ultra-violet) protection? Yes ___ No ___

Are your sunglasses your current prescription? Yes ___ No ___

Are you interested in wearing contact lenses? Yes ___ No ___

Date of last eye exam: _____________________________ Where did you get your last exam? _________________________________

## CONTACT LENSE HISTORY

Do you currently wear contact lenses? Yes ___ No ___

Have you ever tried to wear contact lenses? Yes ___ No ___

### Answer the questions below only if you currently wear contact lenses:

What type/brand of contacts do you wear? ___________________________________________________________________________

How old are your contact lenses? ___________________________________________________________________________________

How often do you replace or dispose of your contact lenses? _____________________________________________________________

What brand of solution do your lenses soak in overnight? ________________________________________________________________

What is your typical wearing schedule? ____________________________________ Hours/day_________________________________

Do you ever sleep in your lenses? ___________________________________________________________________________________

Are you having any problems with your current contact lenses? Yes ___ No ___

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## MEDICAL HISTORY

**<u>Review of Systems:</u> Many diseases of the body have grave eye health consequences. While they may seem unrelated to eye problems, it is crucial to your care that we ask them. Please answer ALL of the following questions.**

**Please check Yes or No if you are experiencing any of the following:**

| | | | | | |
|---|---|---|---|---|---|
| Distance vision blur | Yes___ No ___ | Seeing flashes | Yes___ No ___ | Dry eyes | Yes___ No ___ |
| Near vision blur | Yes___ No ___ | Distorted vision (halos) | Yes___ No ___ | Itching | Yes___ No ___ |
| Glare/light sensitivity | Yes___ No ___ | Red eyes | Yes___ No ___ | Headaches | Yes___ No ___ |
| Double vision | Yes___ No ___ | Eye pain/soreness | Yes___ No ___ | | |

**Do you currently have any of the following: If YES, please explain:**

Heart disease (ex. chest pain, irregular heartbeat, hypertension)...................................... No____ Yes________________________________________________________

Respiratory problems (ex. shortness of breath, wheezing, coughing)................................. No____ Yes________________________________________________________

Gastrointestinal problems (ex. heartburn, abdominal pain, diarrhea, vomiting)................ No____ Yes________________________________________________________

Genitourinary problems (ex. painful urination, blood in urine)........................................... No____ Yes________________________________________________________

Musculoskeletal problems (ex. muscle aches, joint pain or swelling).................................. No____ Yes________________________________________________________

Skin problems (ex. Rashes, excessive dryness, growths or lumps)...................................... No____ Yes________________________________________________________

Neurological problems (ex. numbness, weakness, headaches, "blackouts")....................... No____ Yes________________________________________________________

Psychiatric problems (ex. depression, anxiety).................................................................... No____ Yes________________________________________________________

Endocrine problems (ex. frequent urination, thirst, feeling hot or cold all the time).......... No____ Yes________________________________________________________

Blood problems (ex. bruising, weakness, unusual paleness, swollen glands)...................... No____ Yes________________________________________________________

Immune problems (ex. frequent infections, allergic reaction to foods, dust, pollen)........... No____ Yes________________________________________________________

Have you ever been treated for any medical conditions? (ex. diabetes, high blood pressure, high cholesterol, etc.) ........................................................................................................................... No____ Yes_____________________________________

Have you ever had any eye disease? (ex. glaucoma, cataract, wandering or "lazy" eye, retinal detachment)..... No____ Yes_____________________________________

### FAMILY HISTORY

**Has anyone in your immediate family suffered from the following: If YES, please list, FATHER, MOTHER, BROTHER, SISTER or CHILDREN**

| | |
|---|---|
| Cancer | No ___ Yes _______________________________________________ |
| Diabetes (Type I, Type II) | No ___ Yes _______________________________________________ |
| Hypertension | No ___ Yes _______________________________________________ |
| Hyperthyroidism | No ___ Yes _______________________________________________ |
| Hypothyroidism | No ___ Yes _______________________________________________ |
| Cataract | No ___ Yes _______________________________________________ |
| Macular Degeneration | No ___ Yes _______________________________________________ |
| Glaucoma | No ___ Yes _______________________________________________ |

### SOCIAL HISTORY

| | | | | | |
|---|---|---|---|---|---|
| Do you drink alcohol? | No___ Yes ___ | Occasionally | 1/day | 2-3/day | 4+/day |
| Do you smoke or use tobacco products? | No___ Yes ___ | Occasionally | _________________________pack(s)/day | | |

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**AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA)**

I, __________Print Patient Name__________, authorize Williamson Eyecare, doctors and staff: to disclose information regarding my medical treatment and diagnosis and information regarding my financial account with the following designated individuals or organizations. (This includes any insurance company's pertaining to my eyecare.)

Name of person(s) I authorize release of information to (another doctor's office or family member); **you may revoke at any time.**

Name ___________________________________ DOB _____________________ Relationship _____________________

Name ___________________________________ DOB _____________________ Relationship _____________________

Name ___________________________________ DOB _____________________ Relationship _____________________

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**NOTICE OF PRIVACY acknowledgement and receipt of privacy notice.**

The health Insurance Portability and Accountability Act (HIPAA) is a federal law designated to protect the privacy of your health information. We understand that the information about you and your health is personal, and at **Williamson Eyecare**, we are committed to practicing the privacy of that information. Because of this commitment, we must obtain your written authorization before we can use or disclose your protected health information to any party. **This office will only use and disclose personal health information to permit the office to perform its administrative duties, provide eye care services, process vision benefit claims, process insurance claims, email per patient authorization, or mail exam recalls.**

I, _______________Print Patient Name_________________, have been presented a copy of the offices HIPPA privacy policies and I have read it and understand the content. I know that I can request my own personal copy of the form at any time.

**By signing below, I acknowledge that I have read/received the copy of the Notice of Privacy Practices for review.**

_________________________________________________________ ____________________________________

**Signature of Patient or Legal Representative** **Date**

**NO SHOW CANCELLATION POLICY**

Our office requires 24 hours' notice for appointment cancellations. We understand that acute health emergencies and family crisis can sometimes occur. However, patients that or cancel for personal convenience and no-shows will incur a $35.00 charge on their account. Thank you for your cooperation and understanding.

_______________________________________________

**Patient or legal Representative Signature**

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**WILLIAMSON EYE CARE FINANCIAL POLICY** 

*Our office is pleased to accept your insurance assignment. We offer this as a courtesy to our patients. However, it must be clearly understood that the "contract" is between you, the patient and your insurance company. You are thereby responsible for your account and any amount not paid by your insurance company.*

- Although our office will bill your insurance company, it is necessary for the patient to fill out the insurance information form completely. If the form is not completed, or you do not know who your insurance is with, we will not be able to appropriately bill the insurance company and the responsibility for payment then becomes that of the patient.
- The patient will pay the **estimated** co-payment (the amount not covered by the insurance company) as agreed upon during the financial consultation. Your co-payment may be adjusted after the time of service depending upon the financial reconciliation of insurance payments.
- Insurance plans are categorized as either Medical or as a vision plan. A vision plan often covers a routine exam for glasses or contacts. A medical plan covers an exam for eye or vision problems. The reason for your visit, as well as the nature of your exam, will determine which insurance plan is filed.
- Insurance payments ordinarily are received within 30 to 60 days from the time of billing. If a patient's insurance company has not made payment to our office within 90 days, we will require the patient to pay the balance due and then seek reimbursement from the insurance company when and if it pays.
- Our office does NOT guarantee that the insurance company will pay. We will perform our routine insurance billing procedures upon verification of coverage. However if for some reason the patient's insurance claim is denied, the patient is then considered to be responsible for the full amount of the bill.
- Our office will not enter into a "dispute" with an insurance company over any claim, although we will work with the insurance company to sort out any confusions or questions that might arise. We cooperate fully with the regulations and requests of the insurance companies. It will be however, the responsibility of the patient to handle with the insurance company any type of dispute over payment by the company.
- If you do not have insurance, or we do not participate with the insurance plan, payment for an office visit is due at the time of service. We accept cash, checks, and most major credit cards. Any returned checks will carry a returned check fee of $40.
- Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 15 business days of your receipt of bill. If previous arrangements have not been made, any account 60 days will be forwarded to a collection agency.

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# Welcome to **Williamson Eyecare** your Vision Source

**WILLIAMSON EYE CARE FINANCIAL POLICY** 

Williamson Eyecare is committed to caring for our patient's complete ocular health. Our patients will receive a **COMPLETE EYE HEALTH EXAMINATION.**

**Routine Vision exams** will be filed with the patients Vision Plan if you have one. A routine exam means there is not a medical diagnosis. Routine diagnosis is myopia (near-sightedness), hyperopia (far-sightedness), astigmatism and presbyopia.

If a **Medical Diagnosis** (cataracts, glaucoma, diabetes, pink eye-conjunctivitis, foreign body, etc.) is determined by the doctor the patient's exam is no longer routine, but medical. This means we will bill your Health (Medical) Insurance. We request a copy of your medical card in your chart for this reason.

I have read and understand when my **Vision Plan** will be billed and/or when my **Medical Insurance** will be billed by **Williamson Eyecare.**

I, ______________________________________________, have read & understand **all** the above information.

**Print name**

_________________________________ _____________________________ ____________________

**Signature of patient or Guarantor** **Relationship if not patient** **Date**