PATIENT REGISTRATION FORM

Patient Last Name: _____ First Name: _____ MI:_____

Address: _____State: _____ Zip: _____

Circle contact preference: Home Phone: (_____)_____ Business: (_____)_____

Cell: (_____)_____ Email: _____

Social Security #: _____ Date of Birth: _____ Age: _____

Race: _____ Language: _____ Ethnicity: _____

Sex: Male Female Marital Status: Married Single Divorced Widowed

Emergency Contact:_____ Relation: _____ Phone: (____)_____

Referring Physician:_____

Primary Care Physician:_____

FATHER OR GUARDIAN

Name: _____

Address: _____

State: _____ Zip:_____

Social Security #: _____

Date of Birth: _____

Employer: _____

MOTHER OR GUARDIAN

Name: _____

Address: _____

State: _____ Zip:_____

Social Security #: _____

Date of Birth: _____

Employer: _____

RESPONSIBLE PARTY (if different from above)

Name:_____ Relationship to Patient: _____

Address: _____State: _____ Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

WHERE DID YOU HEAR ABOUT WILMINGTON EYE?

TV _____ Radio_____ Billboard _____ Mailing _____ Google _____ WECT Website _____

Wilmington Eye Website _____ Local Event _____ Phone Book _____ Seminar _____

Another Doctor_____ Facebook _____ Friend or Family _____
(Provide name so we can thank them!)

Information provided is accurate and complete: _____
Patient Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have had an opportunity to review Wilmington Eye's Notice of Privacy Practices.

Patient's Name (Please Print):	Name of Legal Guardian (Please Print)
_____	_____
Patient's Signature (Please Sign)	Signature of Legal Guardian
_____	_____
Date	Date
_____	_____

Please select from one of the choices below:

☐ **Wilmington Eye can discuss my medical records with a representative designated by me below.**

Patient Signature: _____

OR

☐ **I prefer that Wilmington Eye only discuss my medical records with me.**

_____, Relationship _____ Phone _____

_____, Relationship _____ Phone _____

I give my permission to leave positive test results / positive diagnosis on my answering machine.

Signature (Please Sign)

This acknowledgment page should be retained in the patient's record. If acknowledgment count not be obtained from the patient, the reasons must be documented.

WilmingtonEye

REFRACTION FEE POLICY

What is refraction?
Refraction is the process of determining the eye's refractive error or need for corrective glasses and/or contact lens.

Why is it sometimes necessary?
Refraction is sometimes necessary depending on the patient's diagnosis and/or complaints presented that day. For example, if a patient is experiencing blurred vision or a decrease in visual acuity on the eye chart, refraction would be needed to see if this is due to a need for glasses or due to a medical problem. Refraction is also necessary to prove to insurance the need for cataract surgery. We must prove that your vision cannot simply be improved with a glasses prescription.

Does my insurance cover it?
As you can see, refraction is an essential part of an eye exam, however, Medicare and some other insurance providers DO NOT cover it.

How much does the refraction cost?
Our office policy is to charge $60.00 for this procedure in addition to the office visit co-pay and/or deductible. We will bill your insurance according to the individual contracted fee schedules. If your insurance pays the fee, we will gladly refund you the $60.00 amount once we receive notice from your insurance.

Note: This fee is due and payable whether or not you receive a written glasses prescription. Sometimes the change is not significant enough to warrant the cost of purchasing new glasses and a new prescription will not be given. The fee covers the technician and/or physician time that is needed to administer the refraction.

ACKNOWLEDGMENT:
I have read the above information and understand the refraction may not be covered by my insurance. I accept full financial responsibility for the cost of this service. The co-pay and deductible are separate from and not included in the refraction fee.

_____ _____

Patient Signature (Parent for minor) **Date**

Patient Payment Policy

The physicians and staff at Wilmington Eye are committed to providing the highest quality of care to our patients. In order to do this, we must maintain excellence in the clinic, as well as in our business office and other areas of the practice. Medical costs continue to rise and reimbursements continue to decline so it is our policy to effectively manage our patient accounts to minimize cost increases which directly impacts you, the patient.

The purpose of this policy is to provide guidelines and specific instructions related to gathering and maintaining accurate patient information, billing for services rendered and efficient collection activity. Please note these instructions may be modified periodically to ensure we maintain efficient and appropriate protocols related to the business office functions.

It is the patient's/parent's/guardian's responsibility to be familiar with the benefits of your insurance plan, including co-pays, co-insurance and deductibles. We will file your insurance, but please be aware that payment for services is ultimately your responsibility.

For your convenience, we accept cash, check, VISA®, MasterCard®, Discover® and American Express®

Any payment made by check that does not clear your bank account will result in a $25.00 returned check fee, which will be added to your account and must be paid before the next visit.

Patients with balances
If you have a balance on your account, you will be required to pay the balance when making a new appointment or at check-in. If you need a statement printed or an explanation of charges, we will be happy to accommodate your request. All balances must be paid prior to being evaluated by a Wilmington Eye physician.

Insurance and Patient Identifiation
Verification of insurance must be done at each patient visit. Insurance verification will include deductible, co-insurance and co-pay. If we cannot verify your insurance, you will be responsible for all charges at the time of service. We will also request a valid driver's license to verify patient identity and address information.

Refraction Fee
Refraction is the process of determining the eye's refractive error, or need for corrective glasses and/or contact lens. Medicare and many other insurance providers DO NOT cover the refraction charge. ***Our refraction fee is $60.00 and will be collected at time of service.***

Co-pays
In accordance with your insurance contract, you must be prepared to pay your co-pay at each visit. We collect co-pays at check-in.

Self-pay
If you do not have insurance, or if you elect to have a non covered procedure, you are responsible for all charges at the time of service. Self pay patients will be asked to pay $100.00 at check-in. If you need to set up a payment plan, we will coordinate this before you leave the office. Please know that a credit card is required and will be drafted monthly until the balance is satisfied.

Surgery Patients
Any patient who cancels a scheduled, elective surgery without giving more than two (2) weeks notice prior to surgery, or does not show up for surgery, will be charged $250.00 cancellation fee. Legitimate emergencies will be taken into consideration.

I have read and understand the Wilmington Eye Patient Payment Policy

_____ _____
Patient Signature Date

For office use only:
Chart #: _____
Patient Name: _____
_____

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare/other Insurance Company benefits be made either to me or on my behalf to WILMINGTON EYE, P.A. for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries of carriers any information needed for this or a related Medicare claim/other insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section: 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provide penalties for withholding this information.)

Signature: _____

Date: _____

Vision Insurance or Medical Insurance

Wilmington Eye accepts Community Eye Care and EyeMed Vision Plans

Vision insurance COVERS and Medical insurance USUALLY DOES NOT COVER:

- Routine well eye-exams only
- Refraction (test to determine eyeglasses prescription)

Medical insurance USUALLY COVERS and Vision insurance DOES NOT COVER

- Specific eye complaints or conditions
- Follow-up of pre-existing conditions or disease
- Ophthalmic testing

If you have a specific eye complaint or condition or have a pre-existing eye condition or disease, we will bill your medical insurance.

If your exam is billed with your medical insurance, you can still use your vision insurance for any glasses or contacts as your plan allows.

Once the charges for services rendered have been submitted to your insurance at the conclusion of your visit, we **CANNOT ALTER OR CHANGE** the visit type to bill a different insurance.

I understand the difference between vision insurance and medical insurance and that Wilmington Eye will bill for the appropriate services rendered.

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

WilmingtonEye

Patient Medical History & Review of Systems

ROS/PFSH reviewed
Date _____ By _____
Date _____ By _____
Date _____ By _____
Date _____ By _____
Date _____ By _____
Date _____ By _____
Date _____ By _____

Patient Name: _____ Chart # _____ Date _____

Sex: ☐ Male ☐ Female Date of Birth: _____

Who is your medical doctor? _____ Did a doctor refer you? ____ If so, who? _____

Past Medical History

Yes No

☐ ☐ Diabetes (type, when diagnosed) _____
☐ ☐ Lung disease (asthma, emphysema, COPD, chronic bronchitis)
☐ ☐ Cancer (list type or location) _____
☐ ☐ Heart Disease (explain) _____
☐ ☐ High Blood Pressure (explain) _____
☐ ☐ Eye Surgery: Date/Reason _____
_____
_____
☐ ☐ Other Surgery: Date/Reason _____
_____
_____
☐ ☐ Other problems/injuries _____
_____
_____
_____

Do you have any of these problems?

Yes No

☐ ☐ Infectious Disease (TB, syphilis, gonorrhea, AIDS, HIV, hepatitis)
☐ ☐ Heart Disease (heart attack, angina, arrhythmia, heart failure, heart valve dz, bypass surgery)
☐ ☐ Heartburn, abdominal pain, diarrhea, vomitting, weakness, numbness
☐ ☐ Ear, Nose, Throat (hearing loss, sinus disease)
☐ ☐ Thyroid Disease (hypo, hyper, Graves' disease)
☐ ☐ Blood Problems (anemia, leukemia, clotting problems)
☐ ☐ Gastrointestinal Disease (ulcers, esophageal reflux, intestinal)
☐ ☐ Genitourinary Disease (kidney disease, dialysis, kidney stones)
☐ ☐ Skin Problems (eczema, psoriasis, acne rosacea)
☐ ☐ Arthritis (rheumatoid, osteodegenerative), joint pain
☐ ☐ Psychiatric Problems (depression, anxiety, schizophrenic, bipolar)
☐ ☐ Neurological Problems (stroke, seizure, paralysis)
☐ ☐ Respiratory (shortness of breath, wheezing, coughing)

OPHTHALMIC HISTORY

	Yes	No
Lazy Eye	☐	☐
Cataract	☐	☐
Corneal Disease	☐	☐
Diabetic Eye Prob	☐	☐
Glaucoma	☐	☐
Iritis	☐	☐
Macular Degen	☐	☐
Crossed Eyes	☐	☐
Retinal Detach	☐	☐

Other: _____
_____
Injury/Date: _____
Nature: _____
_____
_____

FAMILY HISTORY

	Father	Mother	Siblings	Other
Blindness	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐
Retinal Disease	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
↑ BP	☐	☐	☐	☐

Other: _____

SOCIAL HISTORY (circle)

Marital Status	M	S	D	W
Live Alone	Y	N		
Tobacco	Y	N		
Alcohol	Y	N		

Occupation _____ Retired
Hobbies _____

LIST YOUR MEDICATIONS:

_____
_____
_____
_____
_____
_____
_____
_____

EYE MEDICATIONS:

_____
_____
_____
_____

ALLERGIES:

_____
_____

Information provided is accurate and complete. **Patient Signature:** _____ E119