WilmingtonEye

PATIENT REGISTRATION FORM

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

Address: _____State: _____ Zip:_____

Home: (____) _____ Business: (____) _____Cell: (____) _____

Email: _____ *Circle contact preference:* Home, Business, Cell, Email

**By providing your email address, you agree to receive periodic marketing emails from Wilmington Eye. You can unsubscribe at any time.*

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: _____

PARENT OR GUARDIAN

Name: _____

Address: _____

State: _____ Zip: _____

Social Security No: _____-_____- _____

Date of Birth:_____

Employer:_____

PARENT OR GUARDIAN

Name: _____

Address:_____

State:_____Zip: _____

Social Security No:_____ - _____ -_____

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?

Google___ Facebook___ Instagram___ YouTube___ WECT.com___ Billboard___ TV Commercial___ Radio Ad___

Mailer___ Local Event___ Doctor___ Friend or Family _____

(Provide name so we can thank them)

Information provided is accurate and complete: _____

Patient Signature

ACKNOWLEDGMENT 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

_____
Patient Name (*Print*):

_____
Patient Signature (*Sign*):

_____
Date:

LEGAL GUARDIAN (if patient is a minor)

_____
Name of Legal Guardian (*Print*):

_____
Signature of Legal Guardian (*Sign*):

_____
Date:

Please select from one of the choices below:

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

Patient Signature:_____

OR

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

Name: _____ Relationship:_____ Phone: _____

Name: _____ Relationship:_____ Phone: _____

Patient Signature:_____

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 can not be obtained from the patient, the reasons must be documented.

WilmingtonEye

REFRACTION FEE POLICY

What is refraction?

Refraction is the process of determining what, if any, refractive error exists and if there is a need for corrective lenses. Refraction is also used to determine if there are changes to your current prescription.

Why is refraction sometimes necessary?

Refraction is sometimes necessary during an eye exam depending on the patient's diagnosis and/or the complaint(s) 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 determine if this is due to a need for glasses or due to a medical problem. Refraction is necessary to prove the need for cataract surgery to your insurance provider. We must prove that your vision cannot simply be improved with a glasses prescription.

Does my insurance cover it?

Refraction is an essential part of an eye exam. However, Medicare and most other insurance providers DO NOT cover a refraction.

How much does the refraction cost?

Our office policy is to charge $60.00 for this procedure in addition to the office visit copay 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 copay and deductible are separate from and not included in the refraction fee.

_____ _____

Patient Signature (*Parent Signature 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.

We no longer accept cash. We accept check, money order, 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 Identification

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.

Form Completion Fee

Please be advised that due to the complexity and time required for the completion of forms, you will be charged a $25.00 fee. You will be notified of this charge prior, and payment will be required prior to the release of completed forms.

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. Co-pay required at time of servce.

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 a $250.00 cancellation fee. Legitimate emergencies will be taken into consideration.

I have read and understand Wilmington Eye's Patient Payment Policy.

_____ _____

Patient Signature **Date**

WilmingtonEye

INSURANCE AUTHORIZATION AND ASSIGNMENT

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.

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.)

_____ _____

Patient Signature **Date**

VISION INSURANCE OR MEDICAL INSURANCE

Wilmington Eye accepts Community Eye Care

Vision insurance USUALLY 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 USUALLY 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.

_____

Patient Name (*Print*)

_____ _____

Patient Signature **Date**

PATIENT MEDICAL HISTORY & REVIEW OF SYSTEMS

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, vomiting, 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	SIBLING	OTHER
Blindness	◯	◯	◯	◯
Cancer	◯	◯	◯	◯
Diabetes	◯	◯	◯	◯
Glaucoma	◯	◯	◯	◯
Retinal Disease	◯	◯	◯	◯
Heart Disease	◯	◯	◯	◯
High 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** _____