



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

PARENT OR GUARDIAN

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security No: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Social Security No: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_

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

### LEGAL GUARDIAN (if patient is a minor)

\_\_\_\_\_  
Patient Name (*Print*):

\_\_\_\_\_  
Name of Legal Guardian (*Print*):

\_\_\_\_\_  
Patient Signature (*Sign*):

\_\_\_\_\_  
Signature of Legal Guardian (*Sign*):

\_\_\_\_\_  
Date:

\_\_\_\_\_  
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.



## REFRACTION FEE POLICY

### **What is refraction?**

The refraction portion of an eye exam is essentially a cooperative practice that involves two people, the MD/OD and the patient. During the refraction, our technicians rely on the patient to provide accurate responses. The result of your refractive eye exam is your eyeglass prescription. It will show the combination of lens strengths that you will need for your glasses and/or contact lenses to achieve as close to 20/20 vision as possible.

### **Why is refraction sometimes necessary for medical diagnosis?**

A refraction may be required to determine if there is underlying medical issue. A refraction is sometimes needed to prove/support the need for treatment of a medical condition and /or cataract surgery with your insurance carrier.

### **Does my insurance cover it?**

The refraction fee is an essential part of an eye exam. However, most medical insurances do not consider it a medical necessity and therefore do not cover this portion of the exam.

### **How much does the refraction cost?**

The refraction fee is \$60.00. This fee is collected at the time of service and is in addition to your copay and/or deductible if applicable. This fee covers the providers' time regardless of whether there is a change in vision that requires new eyeglasses. Refractions are billed to your medical insurance carrier. In the case that your insurance does cover the refraction, we will refund this fee.

### **Post Refraction Care:**

If you have any issues or concerns with your vision after wearing your new glasses for at least two weeks, we offer a free recheck within 90 days of your original exam date. In these cases, regardless of where the glasses were purchased, they must be verified by a Wilmington Eye optical associate prior to a recheck visit being scheduled.

Wilmington Eye is not financially responsible for glasses and/or contact lenses that are purchased from a source outside of our practice. If you plan to purchase glasses elsewhere, be sure to ask about the remake policy and warranty.

In every case, our mission is to do everything possible to help our patients make good choices during the refraction and to always provide our patients with the best possible care.

### **ACKNOWLEDGMENT:**

I have read the above information and understand that the refraction may not be covered by insurance. I accept full responsibility for the cost of this service.

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Patient Signature (*Parent Signature for Minor*)

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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 service.

### **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.

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Patient Signature

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Date



## 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.)

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**Patient Signature**

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**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.

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**Patient Name (Print)**

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**Patient Signature**

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**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	<input type="radio"/>	<input type="radio"/>
Cataract	<input type="radio"/>	<input type="radio"/>
Corneal Disease	<input type="radio"/>	<input type="radio"/>
Diabetic Eye Prob	<input type="radio"/>	<input type="radio"/>
Glaucoma	<input type="radio"/>	<input type="radio"/>
Iritis	<input type="radio"/>	<input type="radio"/>
Macular Degen	<input type="radio"/>	<input type="radio"/>
Crossed Eyes	<input type="radio"/>	<input type="radio"/>
Retinal Detach	<input type="radio"/>	<input type="radio"/>

Other \_\_\_\_\_  
 \_\_\_\_\_  
 Injury/Date: \_\_\_\_\_  
 Nature: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## FAMILY HISTORY

	FATHER	MOTHER	SIBLING	OTHER
Blindness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Glaucoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Retinal Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High BP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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 \_\_\_\_\_