PATIENT INFORMATION

PATIENT INFORMATION: Please write information about patient here

LAST NAME:_____ FIRST NAME:_____ MI:_____

S.S.# :_____ SEX: M_____ F_____ DATE OF BIRTH:____/____/____ AGE:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

HOME # :_____ WORK # :_____ CELL #: _____

Employment Status: Full Time Marital Status: Single

Not Employed Married

Retired Widowed

Part Time Divorced

EMPLOYER/SCHOOL:_____

EMPLOYER/SCHOOL ADDRESS:_____

EMPLOYER PHONE #_____

SPOUSAL INFORMATION

LAST NAME:_____ FIRST NAME:_____ MI:_____

S.S.# :_____ SEX: M_____ F_____ DATE OF BIRTH:____/____/____ AGE:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

HOME # :_____ WORK # :_____ CELL #: _____

Employment Status: Full Time Retired

Not Employed Part Time

EMPLOYER/SCHOOL:_____

EMPLOYER/SCHOOL ADDRESS:_____

EMPLOYER PHONE #_____

INFORMATION ON THE PRIMARY CARRIER OF YOUR INSURANCE:

NAME OF INSURANCE CARRIER:_____

LAST NAME OF PRIMARY INS. HOLDER:_____ FIRST: _____ MI:_____

S.S.# :_____ SEX: M_____ F_____ DATE OF BIRTH:____/____/____ AGE:_____

ADDRESS:_____CITY_____ST_____ZIP___

HOME # :_____ WORK # :_____ CELL #: _____

RELATIONSHIP TO YOU:_____ (SELF,HUSBAND,WIFE,MOTHER,FATHER)

INFORMATION ON THE SECONDARY CARRIER OF YOUR INSURANCE:

NAME OF INSURANCE CARRIER:_____

LAST NAME OF SECONDARY INS. HOLDER:_____ FIRST: _____ MI:_____

S.S.# :_____ SEX: M_____ F_____ DATE OF BIRTH:____/____/____ AGE:_____

ADDRESS:_____CITY_____ST_____ZIP___

HOME # :_____ WORK # :_____ CELL #: _____

RELATIONSHIP TO YOU:_____ (SELF,HUSBAND,WIFE,MOTHER,FATHER)

INFORMATION BELOW OF PERSON BRINGING MINOR CHILD:

LAST NAME:_____ FIRST NAME:_____ MI:_____

S.S.# :_____ SEX: M_____ F_____ DATE OF BIRTH:____/____/____ AGE:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

HOME # :_____ WORK # :_____ CELL #: _____

I authorize Advanced Eye Care, P.C. to treat the above named minor:_____

Your relationship to child:_____

Contact name and phone # for family/friends treated by Dr. DeBarge:

1. _____phone #_____
2. _____phone #_____
3.

Contact names for individuals not living in your household:

1. _____phone #_____
2. _____phone #_____

PLEASE GIVE VALID INSURANCE CARDS AND PHOTO ID TO RECEPTIONIST

Signature:_____ Date:_____

Referred to Advanced Eye Care, P. C. by :_____

REV. 08/08

ADVANCED EYE CARE, PC

Patient History

Patient Name:_____ Date:_____

Last Exam: _____ Doctor: _____
Glasses: _____ Contact Lenses:_____
Glaucoma:_____ Amblyopia (Lazy Eye): _____
Eye Surgery: _____
_____

Medical History

	No	Yes		No	Yes
High Blood Pressure	( )	( )	Thyroid Endocrine Problems	( )	( )
Heart Disease	( )	( )	Arthritis/Back Problems	( )	( )
Lung Disease	( )	( )	Neurologic Problems	( )	( )
Tobacco Use	( )	( )	Headaches	( )	( )
Bowel/GI Problems	( )	( )	Blood Disorders	( )	( )
Genitourinary Probs	( )	( )	Seasonal Allergies	( )	( )
Diabetes Mellitus	( )	( )	Other:_____	( )	( )

Family History

	No	Yes		No	Yes
Cataracts	( )	( )	Glaucoma	( )	( )
Retinal Disease	( )	( )	Color Blindness	( )	( )
Crossed Eyes	( )	( )	Heart Disease	( )	( )
Diabetes Mellitus	( )	( )	Cancer	( )	( )
Rheumatoid Arthritis	( )	( )	Blood Disorders	( )	( )
			Other: _____	( )	( )

Past Surgery

_____
_____
_____
_____

Medications

_____
_____
_____
_____

ALLERGIES:_____
_____
_____

3.31.17 SB

ADVANCED EYE CARE, P.C.
L. RAYMOND DEBARGE, M.D.

OUR FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, any and all financial liability rests with the patient.

Our office participates with most major insurance plans. We provide **MEDICAL and SURGICAL** ophthalmologic care to our patients with limited vision care. We do not participate with **ANY** vision plans. Therefore, if you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order for your visit in our office to be covered under your medical insurance. If you do not have the proper referral and still wish to be seen, you will be asked to pay for your visit prior to being worked up by our technicians.

It is the patient's/parent's/guardian's responsibility to:

- Be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles.
- Bring all of your current insurance cards to all visits.
- Provide our office with current information including address, phone numbers and employer.
- In accordance with your insurance contract, you must be prepared to pay your co-pay at each visit. If you are unable to make your co-payment at the time of your visit, we will be happy to re-schedule your appointment. We accept cash, checks, Visa, MC, and Discover.

We appreciate prompt payment in full for any outstanding balance. If unable to pay in full with the first statement, your balance will accrue an 18% annual finance charge. If you are unable to pay a balance in full, please notify us **immediately**. Unpaid balances greater than 90 days may be sent to an outsourced attorney with an additional minimum $25.00 collection fee. All financial communication will be through the attorney's office **not** Advanced Eye Care, PC.
Any payment made by check that does not clear your bank account will result in a $25.00 fee and payment is expected within 10 days of notification of the delinquent check.
For all services rendered to minor/dependent patients, we will look to the adult accompanying the patient and/or the parent or guardian with whom the child resides for payment..

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

I have read and understand the above financial policy. **I do_____ do not_____ want my insurance company billed for services.**

_____ _____
Signature of patient/guardian/parent Date

_____ _____
Printed name of patient Date

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ADVANCED EYE CARE, P.C.

CONTACT LENS EVALUATION

If you are having an eye examination and wear contact lenses, our professional staff will be evaluating your current contact lenses to determine the present appropriateness of your lenses. The fee for this service is collected in addition to the fee for an eye examination and refraction.

REFRACTION

A refraction is the process of determining your best corrected vision. It is an essential part of a medical eye examination and is required to write a prescription for glasses or contact lenses and determine cataract progression. Our office fee for a refraction is $40.00 and is collected at the time of your visit. Should your plan pay us for the refraction, we will reimburse you accordingly.

SAFETY ALERT FOR DILATION

It may be necessary to dilate your eyes during the course of your eye examination or treatment. Dilation results in sensitivity to light and an inability to see well at close range or distance for a few hours. We provide free disposable sunglasses or dark sunglass inserts. Patients should wear sunglasses, be cautious walking and going up or down stairs. We recommend avoiding driving or operating dangerous machinery immediately afterwards. We recommend that someone accompany you to drive you home or you wait until your eyes return to normal so that you can drive safely.

I have read and understand the above information. I accept full financial responsibility for the cost of a refraction and/or a contact lens evaluation (if provided) and understand payment is due at time of service. I understand that any copayment, coinsurance or deductible I may have are separate from and not included in either the refraction and/or the contact lens evaluation fee.

_____ _____

Patient's name (printed) Relationship to Patient

_____ _____

Patient's Signature Staff Witness

_____

Date

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Assignment of Benefits and Release of Information

I authorize the disclosure of my personal health information to my referring physician, primary care physician and insurance company, if applicable, via the use of written or fax transmittal, to carry out treatment, payment, or health care operations. I accept full financial responsibility for services rendered by Advanced Eye Care, P.C., and agree to pay a minimum of $25.00 for collection costs and attorney fees in the event of default of payment on my charges. I further authorize and request insurance payments be made directly to Advanced Eye Care. P.C. should they elect to receive such payment. My signature below indicates that I have read and fully understand the forth written authorization.

Patient or authorized Representative Signature:_____

May we leave a message, either on your answering machine or with the person answering your phone, regarding appointments?

Yes No

May we speak with other people regarding your insurance, billing questions or financial arrangements?

Yes No

May we speak with other people regarding test results or other medical information?

Yes No

If yes, to whom may we speak?

_____

_____

My signature below indicates that I have read a copy of the Privacy Policy from Advanced Eye Care, P.C.

Signature:_____ **Date:**_____

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