the medical eye center

Phone: 603.668.2020
Fax: 603.668.0881

Glaucoma, Retina & Vitreous, Cataract,
Cornea & External Diseases, Uveitis,
Neuro-Ophthalmology, Optometry,
Oculofacial Plastic & Reconstructive Surgery

Dear Patient:

We are excited to welcome you to our practice! As one of the area's leading healthcare providers, we look forward to meeting all of your vision care needs. As this is your first visit to our practice, we ask that you plan to arrive approximately fifteen minutes prior to your appointment time. This fifteen-minute period will give both you and our staff an opportunity to register you in our system and complete any necessary paperwork. Depending on the type of examination that you need, please allow for up to two hours for dilation and any tests that may be performed. We will provide you with disposable sunglasses as you check out if you need them. However, if you are unsure of your ability to drive while dilated, you may want to bring a driver with you.

We have enclosed forms to expedite the registration process. Please complete them ahead of time and bring it with you to your appointment. In addition, please bring your current insurance card(s), your referral or authorization number (if your insurance requires this), a listing of any medications you are taking, and your current eyeglasses. If you will not be able to make your appointment or need to reschedule, please contact us at (603) 668-2020. We look forward to seeing you!

Sincerely,
The Doctors and Staff at The Medical Eye Center

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Date of Birth _____

Please list all **major illnesses, major injuries,** and **medical conditions** you have or have had:
(Examples: diabetes, heart attack, high blood pressure, etc.)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Have you ever had the following surgical procedures?

	Yes	No	If YES, please explain:
Carotid Artery	☐	☐	_____
Heart	☐	☐	_____
Pacemaker implanted	☐	☐	_____
Defibrillator implanted	☐	☐	_____
Lung	☐	☐	_____
Spine	☐	☐	_____
Brain	☐	☐	_____
Cancer	☐	☐	_____

Please list any **eye** surgeries you have had:

_____

_____

Have you ever had a serious **eye** injury? _____ If so, please explain: _____

_____

Please list all medications (including eye medications) you are taking (prescription & over-the-counter):

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Are you allergic to any medications? _____ If so, please list: _____

_____

Are you allergic to latex? _____

See Back

We are concerned about your **general health** as problems elsewhere in the body may affect the health of your eyes and vision. Do you ***currently*** have any problems in the following areas?

	Yes	No	If YES, please explain:
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	_____
High blood pressure, heart disease	☐	☐	_____
Neurologic (multiple sclerosis, Parkinson's, Alzheimer's)	☐	☐	_____
Diabetes, thyroid problems	☐	☐	_____
Breathing problems, emphysema, bronchitis, asthma	☐	☐	_____
Stomach problems, abdominal pain, heartburn, diarrhea	☐	☐	_____
Blood/lymph problems, cholesterolemia, anemia, etc.	☐	☐	_____
Ear, nose, mouth, or throat problems	☐	☐	_____
Genital, kidney, bladder, prostate problems, jaundice, etc.	☐	☐	_____
Arthritis, muscle aches, joint pain, swollen joints	☐	☐	_____
Rashes, excessive dry skin	☐	☐	_____
Depression, anxiety	☐	☐	_____
Allergies/Immunologic, itching, hives, lupus, etc.	☐	☐	_____

Family History (please circle any that apply and their relationship to you)

Glaucoma

Macular Degeneration

Retinal Disorders

Lazy Eye/Cross-eye

Blindness

Diabetes

Social History:

Occupation: _____

Do you use tobacco (including smokeless tobacco)? Yes ☐ No ☐

Do you use alcohol? Yes ☐ No ☐

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FINANCIAL POLICIES

Our specialty eye practice participates with Medicare, Medicaid, and most of the major insurance plans in the area. Please ask us if you are unsure whether we participate with your plan. We will bill your insurance carrier as a courtesy to you; however, payment for deductible and co-pay is due at time of service. This includes all office visits, procedures, and injections. Please remember, your insurance coverage is a contract between you and your insurance company and not a substitute for payment.

- All insurance information will be reviewed at each appointment. Therefore, please bring your insurance cards with you.

Routine Vision Exam: A "routine" vision exam often contains the same elements as a "medical" eye exam. However, the reason for being seen and the results of the examination often determine whether insurance will classify the exam as routine or medical. The difference is determined by the reason for the visit, such as symptoms, complaints, and diagnosis. Routine vision exams are not covered by Medicare. Other insurances may or may not cover a routine vision exam based on your insurance policy.

Non-Covered Service: A refraction is a test to determine the refractive error of the eye and the best corrective lenses to be prescribed. It is an essential part of an eye examination and necessary to write a prescription for glasses. Most medical insurance plans, including Medicare, do not cover refractions. As such, our office fee for a refraction is $50.00 due at time of service.

A Patient Responsibility - Insurance Referrals

If you have an HMO or managed care plan that requires a referral from a primary care physician (PCP) to see a specialist, you must obtain a referral for your visit to be covered under your medical insurance. All referrals should be received in advance of your appointment. Without a referral, you will be responsible for payment of all services denied by your insurance plan.

- If you have not secured the appropriate referral at the time of your appointment, we will ask that you:
  - Call your PCP to obtain the necessary information
  - Complete and sign our waiver form
- You may also reschedule your appointment until your insurance plans' referral requirements are met.

Self-Pay or Commercial Insurance Plans

Patients who do not have insurance and/or have a plan which we do not participate with are required to make full payment at time of service. If unable to pay in full, self-pay patients will be asked to pay $150 at the time of their visit, which will be applied to the actual charges for services provided and as a courtesy we will bill you for any remaining balance. Anyone who is making regular payments on their accounts via a payment arrangement will continue to receive all services.

- If payment is not received or if payments are consistently untimely, a collection agency may be utilized. Patients who have not made regular payments in 90 days will be dismissed from the practice.
- Financial Hardships: If you are unable to make a payment in full, it is important you speak with a member of our billing staff to make payment arrangements on your account.

Insurance Authorization and Consent

I understand that I am responsible for all charges pertaining to my medical care, regardless of my insurance status. I have read, understand, and agree to the financial policy of The Medical Eye Center as outlined above and agree to notify the practice of any changes to my insurance status.

By signing below, I acknowledge that I have read and or have been read to and understand these policies and authorizations.

Print Name of Patient Signature (Patient or Representative) Date

Note: If you are a guardian or power of attorney for the patient listed above, please provide appropriate legal documentation