Rodolfo J. Rios, MD
1306 Savannah Road
Lewes, DE 19958
Phone: (302) 644-8007

WELCOME!
We are pleased to welcome you to our practice. Please print and complete all the information requested on all forms.

Date: _____

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **M.I:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Primary Phone: _____ **Secondary Phone:** _____ **Other:** _____

Sex: ☐ Female ☐ Male **Age:** _____ **D.O.B:** _____ **Patient SS#:** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Ethnicity: ☐ Hispanic / Latino ☐ Non-Hispanic / Latino ☐ Refused to Report / Unreported

Race: ☐ White ☐ American Indian ☐ Asian ☐ African American ☐ Hispanic ☐ Native Hawaiian ☐ Other

Occupation: _____ **Employer:** _____ **Employer Phone:** _____

Employer Address: _____

Spouse's Name: _____ **D.O.B:** _____ **SS#:** _____

Spouse's Occupation: _____ **Spouse's Employer:** _____

Emergency Contact: _____ **Phone:** _____

Preferred Language: _____ **E-Mail:** _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____ **Relationship to Patient:** _____

Insurance Company: _____ **Member ID:** _____ **Group #:** _____

Is the patient covered by an additional insurance? ☐ Yes ☐ No **SS#:** _____ **D.O.B:** _____

Subscriber Name: _____ **Relationship to Patient:** _____

Insurance Company: _____ **Member ID:** _____ **Group #:** _____

EYE HEALTH HISTORY

Previous Eye Doctor: _____ **Date of last eye exam:** _____

Do you wear glasses? ☐ Yes ☐ No **How Often?** ☐ All the time ☐ Occasionally ☐ Reading ☐ Driving ☐ TV

Do you wear contact lenses? ☐ Yes ☐ No **What type?** _____ **How many hours per day?** _____

Describe any problems you may be having with your contacts: _____

_____

Place a check on "Yes" or "No" to indicate if you are currently experiencing any of the following:

Bloodshot Eyes	☐ Yes	☐ No	Eye Infection	☐ Yes	☐ No	Night Vision, Poor	☐ Yes	☐ No
Blurred Vision – Distance	☐ Yes	☐ No	Eye Injury	☐ Yes	☐ No	Red Eyes	☐ Yes	☐ No
Blurred Vision – Near	☐ Yes	☐ No	Eye Strain	☐ Yes	☐ No	Seeing Halos	☐ Yes	☐ No
Burning Eyes	☐ Yes	☐ No	Fainting Spells, Blackouts	☐ Yes	☐ No	Seeing Flashes	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Floaters or Spots	☐ Yes	☐ No	Temporary Loss of Vision	☐ Yes	☐ No
Color Vision, Poor	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Twitching Eyelid	☐ Yes	☐ No
Crossed Eyes	☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Vision Poor	☐ Yes	☐ No
Discharge from Eyes	☐ Yes	☐ No	Itching Eyes	☐ Yes	☐ No	Watering Eyes	☐ Yes	☐ No
Dizzy Spells	☐ Yes	☐ No	Light Sensitive	☐ Yes	☐ No			
Double Vision	☐ Yes	☐ No	Loss of Vision	☐ Yes	☐ No			
Dry Eyes	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No			

HEALTH HISTORY

Place a check on "Yes" or "No" to indicate if you have l

place a check to indicate if a blood relative has had any

	Yourself		Family Men	
AIDS/HIV	☐ Yes	☐ No	☐ Yes	☐
Arthritis	☐ Yes	☐ No	☐ Yes	☐
Artificial Heart Valve	☐ Yes	☐ No	☐ Yes	☐
Artificial Joints	☐ Yes	☐ No	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	☐ Yes	☐ No
Bleeding	☐ Yes	☐ No	☐ Yes	☐ No
Blindness	☐ Yes	☐ No	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	☐ Yes	☐ No
Diabetes (Type_____)	☐ Yes	☐ No	☐ Yes	☐ No
Drug Sensitivity	☐ Yes	☐ No	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	☐ Yes	☐ No
Eye Surgery	☐ Yes	☐ No	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	☐ Yes	☐ No

ition	☐ Yes	☐ No	☐ Yes	☐ No
ype_____)	☐ Yes	☐ No	☐ Yes	☐ No
Pressure	☐ Yes	☐ No	☐ Yes	☐ No
ease	☐ Yes	☐ No	☐ Yes	☐ No
Lazy Eye (R or L)	☐ Yes	☐ No	☐ Yes	☐ No
Lupus	☐ Yes	☐ No	☐ Yes	☐ No
Migraine Headaches	☐ Yes	☐ No	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No	☐ Yes	☐ No
Poor Color Vision	☐ Yes	☐ No	☐ Yes	☐ No
Retinal Disease	☐ Yes	☐ No	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	☐ Yes	☐ No
Shingles	☐ Yes	☐ No	☐ Yes	☐ No
Skin Conditions	☐ Yes	☐ No	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	☐ Yes	☐ No
Thyroid Conditions	☐ Yes	☐ No	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	☐ Yes	☐ No
Turned Eye (R or L)	☐ Yes	☐ No	☐ Yes	☐ No

Yourself **Family Members**

Primary Physician: _____ **Date of last physical:** _____

Have you, the patient, had two or more falls in the past year? ☐ Yes ☐ No ☐ Unknown

Are you pregnant? ☐ Yes ☐ No **Number of Children** _____

Do you or have you ever Smoked? ☐ Yes ☐ No **If Yes, for how long?** _____ **Quit Date:** _____

Do you drink Alcohol? ☐ Yes ☐ No **If yes, how often?** _____

Do you use illegal/street drugs? ☐ Yes ☐ No **If yes, what type?** _____ **How often?** _____

Preferred Pharmacy: _____ **City:** _____ **Phone:** _____

List any past Surgeries, what for, and in what year (if this doesn't apply to you please write N/A):

_____

_____

_____

List all Medications and the dosage that you are currently taking, including Eye Drops (if this doesn't apply to you please write N/A):

_____

_____

_____

List all Allergies and Reactions to Medications and Food Allergies (if this doesn't apply to you please write N/A):

_____

_____

_____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature of Beneficiary Date

Trust your Eyes to Excellence!

INSURANCE ASSIGNMENT TREATMENT & FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing our office for your eye care. We appreciate the opportunity to serve your eye care needs and look forward to getting to know you. If you have any questions or concerns, please feel free to mention this to our staff. Our mission is to provide personalized, high quality healthcare in the most cost-effective manner.

1. **Private Insurance Authorization for Assignment of Benefits & Release of Benefits**
   I hereby authorize and direct payment of my medical benefits to Atlantic Eye Care for any services furnished to me or my dependents by Atlantic Eye Care. I authorize the physician to release any information, including diagnosis and the records of treatment or examination rendered to me or my dependents during the period of such medical services to third party payers and/or health practitioners. I authorize the release of medical information necessary to process insurance claims.

2. **Authorization of Payments**
   I understand that Atlantic Eye Care will assist me in submitting my claims to my insurance carrier. I hereby authorize payment directly to Atlantic Eye Care of medical benefits, otherwise payable to me, for the service provided. I understand that I am financially responsible for my health insurance referrals, deductibles, co-insurance, co-payments, and non-covered services. I understand that my co-payment is due at the time of my visit. If it is not paid in full within 3 months of when the insurance payment is received, my account will be sent to collections.

3. **Services Rendered to Minors**
   For all services rendered to minor patients, the adult accompanying the patient is responsible for any payment due at the time of service, and is also responsible for authorized rendered care.

_____	_____	_____
Patient Signature	Print Name	Date

If the patient is under the age of 18, a parent/guardian or the patient's representative needs to print and sign.

_____	_____
Printed Patient Personal Representative Name	Relationship to Patient
_____	_____
Patient Personal Representative Signature	Date

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PLEASE READ ALL THE INFORMATION BELOW BEFORE SIGNING

Refraction Service & Fee

The Refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and if it is determined that it is necessary, a prescription will written for eyeglasses or contact lenses.

Most medical insurance plans, including Medicare, DO NOT cover routine eye exams or a routine Refraction (when no medical eye problem is known or suspected). Medicare allows that we charge separately for that portion of the examination, since it is not a covered service.

Our office's current Refraction fee is **$40**, which will be the responsibility of the patient if your medical insurance does not cover the service.

If you have any questions regarding Medicare and/or insurance policies and procedures, please do not hesitate to ask. We will do our best to assist you.

No Show Fee

After an appointment is scheduled, we will call a day in advance to remind the patient of their visit as a courtesy. Beginning February 1st, 2007 all patients are required to provide 24 hours' notice for appointment cancellation. If not, you will be charged a $25 *"No Show" fee*.

Collections

Past due accounts will be placed with a collection agency. You will be responsible for all costs of collection which may include collection fees, attorney fees, and any other fees charged by the collection agency including but not limited to a fee for a partial payment made on the past due account.

PATIENT ACKNOWLEDGEMENT

I read the above information and understand that the Refraction is a non-covered service. I accept full financial responsibility for the cost of this service. I understand that any co-payment, co-insurance, or deductible I may have is separate from and not included in the Refraction Fee.

I have read the above information and understand that I need to provide 24 hours' notice if I cancel my appointment or I will be responsible for the *"No Show" fee*.

I have read the above information and understand that if I have a balance on my account that is past due, it will be placed with a collection agency and I will be responsible for all costs of collection mentioned above.

_____	_____	_____
Patient Signature (Parent/Guardian for Minor)	Printed Name	Date

Trust your Eyes to Excellence!

PATIENT CONSENT FORM – DISCLOSURE OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights Section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The practice reserves the right to change the Notice of Privacy Practices Policies.
- The patient has the right to restrict the uses of their information.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The practice may condition treatment upon the execution of this consent.

_____	_____	_____
Patient Signature	Print Name	Date

If the patient is under the age of 18, a parent/guardian or the patient's representative needs to print and sign.

_____	_____
Printed Patient Representative Name	Relationship to Patient
_____	_____
Patient Representative Signature	Date
_____	_____
Witness – Practice Representative Signature	Date