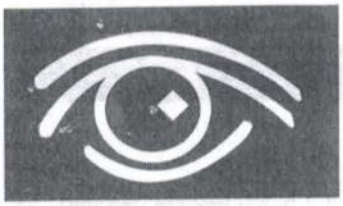

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

PATIENT INFORMATION

Date_____

Patient_____

Address_____

_____
City State Zip

Sex: ☐ M ☐ F Age_____ Birthdate_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Address_____

Employer Phone_____

Spouse's Name_____

Birthdate_____ SS#_____

Occupation_____

Spouse's Employer_____

Whom may we thank for referring you?_____

Email :_____

INSURANCE

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name_____

Birthdate_____ SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

PHONE NUMBERS

Home_____ Work_____ Ext_____ Spouse's Work_____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name_____ Relationship_____

Home Phone_____ Work Phone_____

EYE HEALTH HISTORY

Physician's Name_____

Date of last visit_____

Date of last eye exam_____

Name of doctor_____

Do you wear glasses? ☐ Yes ☐ No

☐ All the time ☐ Occasionally
☐ Reading ☐ Driving ☐ TV

Do you wear contacts? ☐ Yes ☐ No

Type_____ Hours/Day_____

Describe any problems you have with your contacts_____

_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

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

– O V E R –

HEALTH HISTORY

Physician's Name_____ Date of last visit_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself	Family Members
AIDS/HIV	☐ Yes ☐ No	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	☐ Yes ☐ No
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	☐ 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
Heart Condition	☐ Yes ☐ No	☐ Yes ☐ No

	Yourself	Family Members
Hepatitis (Type_____)	☐ Yes ☐ No	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No	☐ Yes ☐ No
Lazy Eye	☐ 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	☐ Yes ☐ No	☐ Yes ☐ No

Are you pregnant?_____ Number of children_____

Tobacco use_____ Alcohol use_____

MEDICATIONS

List medications you are currently taking, including eye drops:

_____

_____

_____

_____

Pharmacy Name_____

Phone_____

ALLERGIES

List your allergies to medications or other substances:

_____

_____

_____

_____

_____

_____

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, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature of Beneficiary Date

Atlantic Eye Care

Trust your eyes to Excellence!

Insurance Assignment Treatment and 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 discuss these with 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 AND 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 and non-covered services.

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 (Parent for minor) Date

Atlantic Eye Care

Trust your eyes to Excellence!

PLEASE READ ALL INFORMATION BEFORE SIGNING

Refraction Service and Fee

Refraction is the process of determining if there is a need for corrective eyeglasses or contacts lenses. It is an essential part of an eye examination and it is necessary to write a prescription for glasses or contact lenses.

Most medical Insurance Plans, including Medicare, DO NOT cover routine Refractions or routine eye examinations (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 current Refraction Fee is $25.00, 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

Beginning February 1st, 2007 all patients are required to provide 24 hours notice for appointment cancellation. If not, you will be charged a $25.00 "No Show" Fee.

Patient Acknowledgement

I have 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, coinsurance, 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.

_____ _____

Patient Signature (Parent for minor) Date

Atlantic Eye Care

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 Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- 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 (Parent for minor) Date

This Consent was signed by: _____

Printed Name - Patient or Representative

Relationship to Patient (if other than patient): _____

Witness - Practice Representative (Name): _____