Gulf Coast Eye Center Leadership In Eye Care

Name:____ **Date:**_________________

Thank you for choosing Gulf Coast Eye Center. Please take a minute to let us know how you were referred to our practice. ***(PLEASE X or ✓ ONLY ONE BOX)***

Phone Book
- Which Phone Book?_____________________________________

Internet
- Which Search Engine?_____________________________________

Website
- Which Website?_____________________________________

Physician
- Doctor's Name:_____________________________________

Optometrist
- Optometrist's Name:_____________________________________

Insurance Company
- Name of Insurance Company:_____________________________________

Friend or Family Member
- Name of Person:_____________________________________

Workman's Comp
- Name of Employer:_____________________________________

Emergency Room
- Name of Hospital:_____________________________________

Other (please list)_____________________________________

Gulf Coast Eye Center

REGISTRATION FORM

(PLEASE PRINT)

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐ Mr. ☐ Mrs. ☐ Ms.	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ☐ M ☐ F

Social Security #	E-Mail Address	Home Phone No. ( )

Street	City	State	Zip

Occupation	Employer	Employer Phone No. ( )

Best Phone Number to Reach You At and Time of Day

Who is your Primary Care Physician?

Referred to Clinic by (Please check one box) ☐Dr.__________________________ ☐Other________________________ ☐ Close to Home/Work ☐ Insurance Plan ☐ Friend / Family ☐ Radio ☐Hospital ☐ Yellow Pages

INSURANCE INFORMATION
(please give your insurance card and driver's license to the receptionist)

Is the patient covered by insurance? ☐ Yes ☐ No

Name of Primary Insurance: ☐ Medicare ☐ Medicaid ☐ BCBS ☐ Other:_____________________________________

Subscriber's Name	Subscriber's S.S.#	Birth Date / /	Policy #	Group#

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other___________________________________

Name of Secondary Insurance (If Applicable) ____

Subscriber's Name	Subscriber's S.S.#	Birth Date / /	Policy #	Group #

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other___________________________________

COMPLETE ONLY IF PATIENT IS UNDER 18 YEARS OF AGE

Father's Name	Father's S.S. #	Birth Date / /	Employer	Work Phone #
Street Address	City	State	Zip	Phone #
Mother's Name	Mother's S.S. #	Birth Date / /	Employer	Work Phone #
Street Address	City	State	Zip	Phone #

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone #	Work Phone #

X____

Patient/Guardian Signature **Date**

MEDICATION AND ALLERGY LIST

Patient's Name:________________________________ Date of Birth:__________________

QD – once a day BID – twice a day TID – three times a day QID – four times a day
QAM – in the morning QHS – at bedtime PRN – as needed

PLEASE LIST ALL PRESCRIPTION AND OVER-THE-COUNTER SUPPLEMENTS/MEDICATIONS THAT YOU TAKE

Medications	Dose	How Many Times Daily																	

Please List All Allergies to Medications ***(if none put "None")***___________________________

____

____

____

Medical History Questionnaire

Name:____ **Date of Birth:**___________________ **Date:**_________________

Date of last eye exam:________________________	Do you wear glasses? Yes No	Do you wear contacts? Yes No

Do you currently have any problems, history of or take medicine for the following areas?
If YES, Please Provide additional Information.

	YES	NO	DETAILS
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (hypothyroid, diabetes , etc.)			**If Diabetic: Type I or Type II**
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			
CANCER (breast, liver, lung, prostate, etc.) Other:			
SURGERIES (Please list type)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases? *(circle all that apply)*	Blindness	Cataract	Glaucoma	Diabetes	Hypertension
	Heart Disease	Stroke	Cancer	Arthritis	Thyroid Disease

Any other heritable disease?

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.) ? YES NO

Have you ever had a blood transfusion? YES NO

Do you drink alcohol? YES NO If YES, how much? ____________________

Have you ever smoked? YES NO If YES, how much? ____________________ How many years ?_____

Physician's Signature **Date**

Reviewed by: (Please initial and date) _______________ ________________ _________________ ________________

________________ ________________ _______________ ________________ _________________ ________________

Gulf Coast Eye Center — Leadership In Eye Care

Lifestyle Questionnaire

To help us assist you in selecting your best vision correction options, please fill out this brief questionnaire.

Name:____ **Date Completed:**_________________

Occupation: ____________________________________ **Age:**________ **Sex:** ☐ **Male** ☐ **Female**

1.) What is your primary visual concern?____

2.) I currently wear: ☐ Eyeglasses ☐ Contacts ☐Sunglasses

3.) What would you most like to improve about your vision wear?___________________________________

____

4.) What recreational hobbies, activities, or interests do you enjoy? ***Check all that apply.***

☐ Golf ☐ Running ☐ Racquetball ☐ Football ☐ Tennis
☐ Snow Skiing ☐ Baseball/Softball ☐ Boating ☐ Water Sports ☐ Fishing
☐ Basketball ☐ Reading ☐ Gardening ☐ Knitting ☐ Crafts
☐ Watching TV ☐ Cooking ☐ Video Games ☐ Painting ☐ Internet
☐ Sewing ☐ Woodworking ☐ Other:_____________________________________

5.) What job requirements do you have? ***Check all that apply.***

☐ Computer Work ☐ I Work Outdoors
☐ Considerable Reading ☐ My Job Necessitates Safety Eyewear
☐ Other:____

6.) Can you read without glasses? ☐ yes ☐ no

7.) Do you mind wearing glasses? ☐ yes ☐ no

8.) Do you consider yourself sensitive to sunlight? ☐ yes ☐ no

9.) Do you have difficulty driving at night? ☐ yes ☐ no

10.) Do you have problems with glare at night time? ☐ yes ☐ no

11.) Are you interested in LASIK to correct nearsightedness, farsightedness, and astigmatism?

☐ yes ***(please answer next question)***
☐ no ***(please stop here)***

12.) Choose the statement that best reflects your lifestyle:

☐ I would prefer better distance vision even if I need to wear “readers” for near vision activities (i.e. reading, applying make-up, computer work)

☐ I need to see up close so much of the time and would be willing to trade-off better distance vision if I can avoid the use of “readers”

Gulf Coast Eye Center Leadership In Eye Care

PATIENT ACKNOWLEDGEMENT REGARDING

PRECAUTIONS FOLLOWING 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 and down stairs. We recommend avoiding driving or operating dangerous machinery immediately afterwards. We recommend that someone accompany you to drive you home or that you wait until your eyes return to normal so that you can drive safely.

REFRACTION SERVICE AND FEE:

- ✓ Refraction is the process of determining your best corrected vision and if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and is necessary to write a prescription for glasses or contact lenses.
- ✓ Refraction is **NOT** a covered service by Medicare and most insurance plans. These plans consider refraction a "vision" service and not a "medical" service.
- ✓ Our office fee for refraction is **$32.00** and this fee is collected at the time of service in addition to any copayment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

CONTACT LENS EVALUATION AND FEE:

- ✓ 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 starts at **$75.00** and is collected in addition to the fee for an eye examination without contact lenses.

I have read and understand the above information. I accept full financial responsibility for the cost of refraction and/or 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 if either the refraction fee or contact lens evaluation fee.

Patient's Name (Printed)	Relationship to Patient	Date

Patient's Signature or Legally Responsible Adult for Minor

Staff Witness

GULF COAST EYE CENTER

Signature on File, Assignment of Benefits, Financial Agreement, HIPAA Notice

1. **MEDICARE and MEDIGAP:** I request that payment of authorized Medicare and Medigap benefits be made on my behalf to Gulf Coast Eye Center for services furnished me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or 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, my signature authorizes releasing the information to the insurer or agency shown. Gulf Coast Eye Center accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

2. **OTHER INSURANCE**: I authorize payment of my medical, surgical, and vision insurance benefits to Gulf Coast Eye Center. I understand I am financially responsible for any charges whether or not paid by said insurance. After 60 days from date of service if payment has not been received from my insurance company, the balance becomes my responsibility. Any conflicts with my insurance company will have to be handled by me. I agree to pay any co-payments and/or deductibles designated by my insurance company or health plan to Gulf Coast Eye Center. I authorize Gulf Coast Eye Center to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

3. **NON-COVERED SERVICES:** I understand that Gulf Coast Eye Center's contract with health care services plans (i.e., HMOs, PPOs) relates only to items and services which are "covered" by the health care service plans. Accordingly, I accept full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. **Charges for refractions are due at time of service.** Refraction is a measurement of the lens power necessary to prescribe glasses or other corrective lenses. Most medical insurances do not cover this as they consider it to be a routine service. Failure to pay for the refraction at time of check out will result in your prescription being held until payment is received. I agree to cooperate with Gulf Coast Eye Center to obtain necessary health care service plan authorizations. If you have Medicare, but Medicare may deem the prescribed treatment as "medically unnecessary" according to HCFA payment guidelines, you will be requested to sign a waiver (advance beneficiary notice) prior to treatment and payment for the service is due at the time of service.

4. **FINANCIAL AGREEMENT: Payment is due at time of service**. We accept cash, personal checks, debit and credit cards and Care Credit Financing. All deductibles, co-pays, and non-covered services are due at time of service unless payment arrangements have been made in advance. All Medicare patients will be required to pay the 20% co-pay based upon the current Medicare Fee Schedule, at the time of service, unless proof of a secondary policy is evident. Patient balances unforeseen at time of service will be billed to the address you have provided for billing purposes. It is your responsibility to inform us of any change in address, phone, or employment. All balances are due in full within 14 days of the billing date. If you cannot pay the balance in full within 14 days, please contact our office to see if you qualify for any special payment arrangement options. Our office treats patients regardless of financial status. If you have no insurance, have maximized your benefits, have a high deductible, or you are currently medically indigent or financially indigent but not eligible for Public Assistance or Medicaid, please ask to speak with the Financial Manager. You will need to provide a copy of last year's tax returns and current pay check stubs to be considered for assistance with our office.

I agree that in return for the services provided to me by Gulf Coast Eye Center, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Gulf Coast Eye Center for payment. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Gulf Coast Eye Center. However, I understand that I am primarily responsible for the payment of my bill. If my account is sent to an agency for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate.

5. **HIPAA NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have received the Notice of Privacy Practices issued by Gulf Coast Eye Center's Notice of Privacy Practices dated December 1, 2015.

	X	
Name of Patient	**Signature or Authorized Party**	**Date**