Complete Family Eyecare Patient Information Form

Name: ____ ____________________
First Last Middle Initial Nickname

Birth Date: _____/_____/______ **SS#:**_________-________-_________ **Sex: M**____ **F**____

Address:__________________________________ _________________ ____ _________
Street City State Zip Code

Phone:______________________ _____________________ _________________ ____
Home Cell Work Ext.

Email:____

Race: Native American/American Indian____ **Marital Status:** Married____

African American____ Asian/Pacific Islander____ Single_____

Hispanic or Latino____ White____ Other____ Other______

Employer/School:_________________________**Occupation/Grade**_________________ **Retired**____

Emergency Contact:____________________________ ___________ ___________________
Name Relationship Phone number

Family Physician:____ ___________________
Name Phone number

Pharmacy:__________________________________ ____________ ___________________
Name Phone Fax

Certain information is required to bill your claims correctly. If your coverage is through your Spouse or Parent, we require the Primary Insured's Name, SS#, Date of Birth, & Employer. If you have Medicaid and have a "TPL", you must provide the primary insurance information.
Patient are required to present insurance cards and update information prior to being seen. Timely filing limits for insurance claims are applicable.

Vision Insurance: _____________________________ ________________________________
Plan Name

Policy Holder:_____________________________________ ____/____/____ _______-______-________
Name Date of Birth SS#

Policy #:_______________________ **Group #:**________________ _____________________
(Patient relationship to Insured)

Medical Insurance: _____________________________ ________________________________
Plan Name

Policy Holder:_____________________________________ ____/____/____ _______-______-________
Name Date of Birth SS#

Policy #:_______________________ **Group #:**________________ _____________________
(Patient relationship to Insured)

Please supply any and all Secondary/Supplemental Insurance information and cards to the front desk.

If I do not provide Complete Family Eyecare with accurate insurance information and current insurance cards at the time of service, I will be responsible to pay for all services rendered until the information is updated. Should there be a balance after billing due to deductible limits, co-insurance, co-payments or denial of services deemed as non-covered, I accept total financial responsibility for the charges, collection agency fees, or attorney fees incurred in the process of recouping my payment.

I have read, understand and agree with the above information.

Signature:____ Date:____________________
Patient or Guardian

Relationship if Guardian:___________________________________

Patient, Family, Social History

Your Past Ocular History:

Please CHECK any eye conditions listed YOU have had in the past.

Amblyopia	☐	Macular Degeneration	☐	Strabismus	☐
Cataracts	☐	Retinal Detachment	☐	Patching	☐
Glaucoma	☐	Retinal Degeneration	☐	Inflammatory Disorder	☐
Glaucoma Suspect	☐	Retinal Hole	☐	Eye Injury	☐
		Keratoconus	☐		

Other:______________________________ ☐

None ☐

Family Medical History:

Please CHECK the appropriate Family Member who has a history of the following conditions:

Family Ocular History:

Please CHECK the appropriate Family Member who has a history of the following conditions:

(**F**ather, **M**other, **B**rother, **S**ister, **Son**, **D**aughter)

	F	M	B	S	Son	D
Cancer						
Type 1 Diabetes						
Type 2 Diabetes						
Hypertension						
Hyperthroidism						
Hypothroidism						

	F	M	B	S	Son	D
Cataract						
Glaucoma						
Macular Degeneration						
Glaucoma						
Retinal Detachment						
Strabismus/Lazy Eye						

Social History, Patient:

Please answer the following questions.

Do you drink alcohol? Yes ☐ No ☐ If YES, amount:______________________

Do you smoke? Yes ☐ No ☐ If YES, amount: Packs/day______________________

Use chewing tobacco? Yes ☐ No ☐ If YES, amount:______________________

Hobbies:____

CONTACT LENSES:

Do you currently wear contacts? Yes ☐ No ☐ If YES, what kind?______________________

Are you interested in updating? Yes ☐ No ☐

How old are the contacts you are currently wearing?______________________

How many hours a day do your wear your contacts?______________________

How many hours have you worn your contacts today?______________________

How often do you replace your contacts?______________________

Do you sleep in your lenses? Yes ☐ No ☐ If so, how many nights?______________________

Patient Medical History Form

Constitution

Fatigue Syndrome	
Fever	
Weight Loss	
Other	

ENT

Dry Mouth	
Hearing Loss	
Laryngitis	
Sinusitis	
Herpes/Cold Sores	
Other	

Neurological

Multiple Sclerosis	
Tumor	
Migraine	
Cerebral Palsy	
Stroke/CVA	
Epilepsy	
Other	

Psychiatric

Bipolar Disorder	
Depression	
Attention Deficit	
Anxiety Disorder	
Other	

Cardiovascular

Stroke/CVA	
Congestive Heart Failure	
Heart Disease	
Hypertension	
Vascular Disease	
Other	

Gastrointestinal

Colitis	
Ulcer	
Celiac Disease	
Crohn's Disease	
Acid Reflux	
Other	

Respiratory

Chronic Obstruction	
Bronchitis	
Asthma	
Cigarette Smoker	
Emphysema	
Sleep Apnea	
Other	

Hematologic

Ulcer	
Anemia	
Hypercholesterolemia	
Large Volume Blood Loss	
Other	

Musculoskeletal

Gout	
Muscular Dystrophy	
Osteoarthritis	
Ankylosing Spondyliris	
Other	

Integumentary

Psoriasis	
Rosacea	
Eczema	
Herpes Zoster/Shingles	
Other	

Endocrine

Hormonal Dysfunction	
Diabetes Type 1	
Diabetes Type 2	
Thyroid Dysfunction	
Other	

Allergy/Immunie

Lupus	
Sjogren's Syndrome	
Environmental Allergies	
Drug Allergies	
Rheumatoid Arthritis	
Other	

Genitourinary

Prostate Disease/Cancer	
Kidney Disease	
Other	

Medications: List all Medications you currently take: ________________________________

____

____

____

Allergies: List all allergies: ____

____

Latex sensitivity? Yes ☐ No ☐

OFFICE POLICIES

Patient Name:____
Please Print

FEES:
Complete Family Eyecare (CFE) is committed to providing the best treatment for our patients. Our fees are representative of the usual and customary charges for the level of service provided, materials prescribed, as well as the level of advanced technology used to provide our patients with the most up-to-date eyecare.

CONSENT TO TREAT:
I request and give consent to CFE to provide and perform such medical and vision eye care, tests, procedures, medications and other services and supplies as are beneficial for my eye health, wellbeing and vision.

PAYMENT:
I am responsible for any co-pays, co-insurance, deductible and other non-covered services such as contact lens assessment and refraction at the time of service. If I am being seen for any ongoing medical condition, co-pays are due at each visit. If I am a self-pay patient and/or my insurance cannot be verified prior to my appointment, I will be required to pay in full the day services are rendered. All material orders must be paid at the time of service before any orders will be processed. No prescriptions will be released until professional services are paid in full. If I receive a statement from CFE's office, I am expected to remit full payment upon receipt. Statements will not be sent for any balance under $10.00. I may have a small balance on my account at the time of my next visit or order.

If my account is over 90 days past due, I will receive a letter stating I have 30 days to pay my account in full. If my account is referred to an outside collection agency for non-payment, a fee will be added to my account to cover the expense incurred from the agency. If my account is in collections, I will be seen on an emergency only basis and must make payment in full prior to scheduling another appointment with our office.

Checks returned from my financial institution will be charged back to me with an additional $30 fee.

CFE is able to offer 6 and 12-month payment plans through Care Credit. I may apply for Care Credit at www.carecredit.com.

INSURANCE CLAIM FILING:
As a courtesy to our patients, CFE will file claims with insurance companies for which we are providers. CFE will provide the best possible effort to verify my benefits for services and/or materials; however, benefits quoted by my insurance carrier are not a guarantee of payment. I am responsible for supplying complete, accurate and up to date insurance information. Should my insurance deny a claim for any reason, I will be responsible for any remaining balances as directed by my insurance.

____ Yes, I would like CFE to file claims to my insurance on my behalf. My signature below authorizes CFE to act as my agent to bill for insurance and/or Medicare benefits, and I authorize payment of these benefits to be paid directly to CFE on my behalf. I authorize CFE to release any medical information needed to determine those payable benefits.

____ No, I do not want CFE to file claims to my insurance, I will be responsible for the total cost of all services provided.

PRESCRIPTION POLICIES:
Eyeglass lenses and frames may NOT be returned or exchanged. All lenses ordered on my behalf are specifically for my vision needs and specifications. CFE will make any necessary adjustments to ensure proper fit and the best vision possible.

If I choose to have my eyeglasses made outside of this office, CFE will NOT take any responsibility in the accuracy or quality of my eyeglasses. If I choose to have my eyeglasses made outside of this office, CFE recommends I reach an agreement with my eyeglasses dispenser before I place my order.

Contact lenses may only be returned for credit or exchange, no refunds will be given. Contacts must be intact, in their original packaging with no markings on the box and returned within 30 days of receipt. Custom orders cannot be returned for credit. Fitting and assessment fees are non-refundable. Medical insurances do not cover the assessment of contact lenses. Wellness vision benefits such as VSP do not cover the fitting as part of their basic exam.

CFE does not take any responsibility for contact lenses purchased outside of this office. If the prescription changes or the physical fit of the contact lenses change, I will be responsible for the cost of any new contact lenses.

I have read and agree to the above policies and conditions. Unless revoked by me in writing, this authorization will remain in effect for the lifetime of my relationship with Complete Family Eyecare.

Date:________________________________

Patient Name:____
Please Print

Patient or Guardian:____
Signature

Relationship to Patient if Guardian:____

Complete Family Eyecare is happy to offer our patients access to our patient portal. In our patient portal you will be able to:

- Update demographics and contact information
- View receipts and account balances
- Access record summaries

Login at www.revolutionphr.com

Email address:____

Temporary Password:____

As required by the Health Insurance Portability and Accountability Act, Complete Family Eyecare may not use or disclose your health information without your authorization.

I,____, understand that this authorization is voluntary. I understand that my health information may be protected by the Federal rules for Privacy of Individually Identifiable Health Information and/or state laws. I understand my health information may be subject to re-disclosure for the purpose of billing insurance, referrals, and legal processes and if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the federal privacy regulations.

I understand it is the policy of Complete Family Eyecare that all my appointments may be confirmed by phone prior to my office visit. If no one is home, a message will be left on my answering machine/voicemail with the time and date of my scheduled appointment. I understand this confirmation process cannot be waived or declined by myself or any individual.

I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS related information. I further understand that by signing below, I am authorizing the release or exchange of my information/records for the purpose of billing to my insurance for my benefit management and claims administration, legal processes and subpoenas, mandated treatment referral, and/or the release of physical records as requested by myself or my legal representative.

I understand I do not have to sign this authorization form. I understand I may inspect or copy the protected health information to be disclosed by Complete Family Eyecare. I also understand, if, by my refusal to sign, I am preventing the billing of insurance for payment of charges, all non-emergent treatment may be refused.

Except to the extent when action has already been taken in confidence on this authorization, I may, at any time, revoke this authorization by submitting a written notice to the office of Complete Family Eyecare at any of the addresses listed below. Unless revoked, this authorization will expire one year from today on the following date:

(Date)____

My signature below indicates I have been given an opportunity to ask any questions and have them answered before signing.

I authorize Complete Family Eyecare to release the protected health Information as above.

Date__________________________

Patient or Guardian Signature:____

Relationship if Guardian:____

3121 S. Park Avenue
Herrin, IL 62948
Ph: (618) 942-5465
Fax: (618) 942-7042

1241 E. Walnut Street
Carbondale, IL 62901
Ph: (618) 529-3452
Fax: (618) 457-5611

202 E. Clark Street
West Frankfort, IL 62896
Ph: (618) 937-3126
Fax: (618) 937-3344

Optomap Retinal Exam

At Complete Family Eyecare, we pride ourselves on providing our patients with the best possible standard of care. We now offer the **Opto**map retinal exam. This non-invasive imaging test allows our providers to see a much more detailed view of the retina than with traditional methods. The image becomes a permanent part of your medical file, allowing our providers to make important comparisons year after year. In most cases, there will not be a need to dilate after this image. If the provider decides there is a need for dilation, this will be discussed during your exam.

These images will help see early signs of may ocular conditions and systemic diseases such as:

- Age related Macular Degeneration
- Glaucoma
- High blood pressure
- Diabetes
- Retinal holes or detachments

Optomap:

- Provides an eye wellness scan
- Gives in depth view of the retinal layers
- Provides an annual, permanent record for your medical file.
- Fast, easy, and comfortable.
- **Does NOT require dilation drops, which result in blurred vision and sensitivity to light for 4-6 hours.**

PLEASE NOTE: There is an additional charge of $25 for the Optomap Retinal Exam, which is NOT covered by insurance.

( ) YES: I understand the importance of having the Optomap and wish to have it performed ($25.00 fee).

( ) NOT SURE: I understand that my provider would like for me to have the Optomap, but I would like to discuss this with my provider first.

( ) No: I elect to have my eyes dilated (no additional charge). I understand it will cause light sensitivity and may blur my vision, as well as lengthen the time of my visit.

( ) Neither: I understand the importance of this testing, but at this time I decline both the Optomap and dilation of my eyes.

Patient Signature:____

Date:____