PINKE! EYE CENTER

Registration Form

PATIENT INFORMATION (Please use full legal name, no nicknames)

Last Name	First Name	M.I.

Social Security # - -	Date of Birth - -	Sex M | F

Address	City	State/Zip Code

Home Phone # ( ) -	Cell Phone # ( ) -	E-mail:

Preferred contact method	Marital Status	Employment Status
Work Home Cell	Single Married Widowed Divorced	None Full Time Part Time Retired Student

Name of employment or school	Work Phone # ( ) -

GUARANTOR (RESPONSIBLE PARTY) INFORMATION IF DIFFERENT FROM ABOVE
IF PATIENT IS A MINOR, PLEASE FILL OUT

Last Name	First Name	M.I.

Social Security # - -	Date of Birth - -	Sex M | F

Address	City	State/Zip Code

Home Phone # ( ) -	Cell Phone # ( ) -	E-mail:

Preferred contact method	Marital Status	Employment Status
Work Home Cell	Single Married Widowed Divorced	None Full Time Part Time Retired Student

Name of employment or school	Work Phone # ( ) -

EMERGENCY CONTACT	Name	Relationship	Phone # ( ) -

HOW DID YOU HEAR ABOUT US?

PINKE! EYE CENTER

Medical History Form

EYE HISTORY

Reason for exam

Do you wear glasses?	Do you wear contact lens?	If yes, specify type/brand
Y | N	Y | N	

Have you been diagnosed with any of the following? (circle your answer)

Y | N Amblyopia/lazy eye	Y | N Dry eyes	Y | N Macular degeneration
Y | N Blindness	Y | N Eye Infection	Y | N Retinal detachment
Y | N Cataracts	Y | N Glaucoma	Other (please specify below)

List any prior eye surgeries, including laser eye surgeries.

List any eye drops you are using (with frequency)

MEDICAL HISTORY

List any medication allergies
If none, write 'none'

Latex allergy? Y | N

Have you been diagnosed with any of the following? (circle your answer)

Y | N Arthritis	Y | N Heart disease	Y | N Irregular heart beat
Y | N Asthma	Y | N Heartburn/ulcers	Y | N Kidney disease
Y | N Bleeding disorder	Y | N Hepatitis	Y | N Psoriasis
Y | N Cancer	Y | N High blood pressure	Y | N Rosacea
Y | N Diabetes	Y | N High cholesterol	Y | N Stroke
Y | N Emphysema/COPD	Y | N HIV	Y | N Thyroid problems

List any other major medical diagnosis:

List any previous surgeries:

Pharmacy Name	Address (or approximate location)

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Medical History Form

PHYSICIANS

Primary care physician	Address	Phone number
Referring provider (if different)	Address	Phone number

SOCIAL HISTORY

Do you currently smoke? Y | N If so, how much? _____packs per days.
Have you smoked in the past? Y | N What year did you quit? _____
Any alcohol use? Y | N How many drinks per week? _____
Illicit drug use? Y | N What kind? _____

Are you pregnant or planning? Y | N | N/A

FAMILY HISTORY - has anyone in the family been diagnosed with the following? List members.

Y | N Blindness_____
Y | N Cataracts_____
Y | N Glaucoma_____
Y | N Macular degeneration _____
Y | N Lazy eye _____

Y | N Diabetes _____
Y | N High blood pressure _____
Other history:

Medication list (please list all medication with dosage and frequency)
Or, please provide a list for the receptionist to copy.

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EYE CENTER

Medical History Form

Review of systems (if your answer is "No" to all of the answers below, check here_____)

Eyes
- Previous surgery Y | N
- Contact lens Y | N
- Pain Y | N
- Double vision Y | N
- Glaucoma Y | N
- Cataracts Y | N
- Macular degeneration Y | N
- Dry eyes Y | N
- Flashes Y | N
- Floaters Y | N

Ear, nose, and throat
- Hard of hearing Y | N
- Ringing of ears
- Vertigo Y | N

Cardiovascular
- Chest pain Y | N
- Dizziness Y | N
- Fainting spells Y | N
- Shortness of breath Y | N
- Irregular heart beat Y | N
- Difficulty lying flat Y | N

Constitutional
- Fatigue/weakness Y | N
- Fever
- Weight gain/loss Y | N

Respiratory
- Cough Y | N
- Congestion Y | N
- Wheezing Y | N
- Asthma Y | N

Gastrointestinal
- Heartburn Y | N
- Nausea/vomiting Y | N
- Jaundice/Hepatitis Y | N

Genitourinary
- Pain/difficulty Y | N
- Blood in urine Y | N
- Kidney stones Y | N
- STDs Y | N

Psychiatric
- Anxiety/Depression Y | N
- Mood swings Y | N
- Difficulty sleeping Y | N

Endocrine
- Increased thirst Y | N
- Increased hunger Y | N
- Increased urination Y | N
- Increased sweating Y | N
- Fingernail changes Y | N

Blood/Lymph nodes
- Easy bruising Y | N
- Gums bleed easily Y | N
- Prolonged bleeding Y | N
- Heavy Aspirin use Y | N

Musculoskeletal
- Stiffness Y | N
- Arthritis Y | N
- Joint pain/swelling Y | N

Skin
- Rashes/sores Y | N
- Lesions Y | N
- Hives/Eczema Y | N

Neurological
- Seizures Y | N
- Weakness/paralysis Y | N
- Numbness Y | N
- Tremors Y | N

Immunologic
- Hives Y | N
- Itching Y | N
- Runny nose Y | N
- Sinus Pressure Y | N

The above information is accurate to the best of my knowledge

Patient / Guardian Signature **Date**

Pinke Eye Center Use Only **Date**
I have reviewed the history.

Financial Authorization

PATIENT FINANCIAL RESPONSIBILITIES:

1. The patient (or patient's guarantor, if a minor) is ultimately responsible for the payment of medical services rendered.

2. I understand that it is my responsibility to supply Pinke Eye Center with any current insurance information and/or any required referrals or authorizations.

3. Patients (or guarantors) are responsible for payment of co-pays, co-insurance, deductibles, and all other fees not covered by their insurance. Payment must be paid at the time services are rendered. This is necessary in order for us to bill your insurance carrier on your behalf.

4. I authorize Pinke Eye Center to release any information necessary to insurance carriers regarding my diagnoses and treatments to process insurance claims.

5. I hereby assign all medical and surgical benefits to which I am entitled (assignment of benefits). I authorize and direct my insurance carrier(s) to issue payment check(s) directly to Pinke Eye Center for rendered services. If I receive payment check(s) from my insurance carriers, I will promptly forward them to Pinke Eye Center.

6. We will file your claim for services rendered with your insurance carrier. If payment is not received, the balance due will become the obligation of the patient or guarantor (responsible party) and must be paid within 30 days.

7. If you do not have insurance or we are a non-participating provider with your insurance carrier, payment is expected at the time services are rendered.

8. I understand that if I have a routine (non-medical) diagnosis, my insurance may not cover the cost of the exam. I understand that Medicare and most insurance plans do NOT cover standard care, refraction fees, or contact lens exam fees, and that I will be fully responsible for these charges.

9. I understand that I will be responsible for payment of non-covered services (by my insurance company).

10. If my account results in collection agency involvement, the undersigned patient or guarantor agrees to pay all legally allowed interest and collections associated fees added to my bill.

11. Payments may be made by cash, check, or credit card (Visa, Discover, Mastercard, or American Express).

12. This authorization will remain on file for future rendered services.

I UNDERSTAND THE ABOVE FINANCIAL RESPONSIBILITIES AND AGREE TO THEIR TERMS. I ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO PROCESS INSURANCE CLAIMS.

Signature of Patient or Guarantor:	**Date**
Print Patient or Guarantor Name:	

PINKE! EYE CENTER

Refraction Fee

What is a refraction and the refraction fee?
A refraction is the determination of your best corrected vision. The results from the refraction may be used to prescribe new glasses. The results from the refraction are also necessary to determine whether any medical or surgical treatment may be needed for you. As an example, a refraction is used to gauge whether a cataract may be worsening, necessitating surgery. A refraction is needed to decide if an eye disease is causing your loss of vision. In other words, a refraction is used to assess the overall health of the eyes.

Refraction is an essential part of the eye examination, but, unfortunately, it is NOT a covered service by Medicare and many insurance companies. Our office fee for refraction is $46.00. This fee is collected in addition to any co-payments, co-insurance, and deductibles.

Why do I have to pay the refraction fee if my glasses prescription did not change?
It is impossible for us to determine whether your prescription has change unless a refraction is done. Over time, the eye naturally changes shape and/or develops aging characteristics which can change your glasses prescription and/or vision.

I wear contact lens, do I have to pay a refraction fee?
If you wear contact lens and need a renewal for contacts, your refraction fee will be covered under the contact lens exam fee (please see separate contact lens sheet).

Will my insurance cover my refraction?
Medicaid plans will cover your refraction. Tricare plans will discount your refraction fee. If your insurance covers refraction, you will be refunded your money.

Why do I have to sign this form if I decline a refraction today?
Please sign this form in case you decide to receive a refraction at a future visit. You will NOT be charged if a refraction is not done.

I have read the above information and understand that the refraction fees may be a non-covered service. I accept full financial responsibility for the cost of these services. I understand the refraction fee is a separate charge from co-payments, co-insurances, and deductibles.

Signature of Patient or Guarantor:	**Date**
Print Patient's Name:	
Print Legal Guardian's Name, if applicable:	

Dilation Waiver

What is dilation?
Eye dilation requires the use of eye drops to enlarge your pupils (the dark circular opening in the center of your eyes). Without this procedure, physicians may only see 30% or less of the eye's interior surface.

Why is dilation necessary?
Dilation is necessary in order to detect and treat eye diseases such as cataracts, glaucoma, macular degeneration, and diabetes. It is especially important for this part of the eye exam be completed at least once a year. Photographs through an undilated pupil do not substitute for a dilated examination.

What is the cost for dilation?
There is NO additional cost involved.

How long does dilation lasts?
Your eyes will usually dilate within 15-20 minutes after drop instillation. Your eyes will typically be dilated for a total of 4-6 hours.

What precautions are necessary after dilation?
After dilation, your eyes may be light sensitive and slightly blurry for distance. Your eyes may be very blurry for near vision after dilation. The degree of light sensitivity and blurriness varies per patient. While most patients can drive without any additional assistance, we do recommend that you call a friend or family member if you feel unsafe to drive.

I UNDERSTAND THE DILATION POLICY AND TAKE FULL RESPONSIBILITY FOR ANY ACTIVITIES I PERFORM AFTER DILATION.

Signature of Patient or Guarantor:	**Date**
Print Patient's Name:	
Print Legal Guardian's Name, if applicable:	

Health Privacy Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used:

1. **For Treatment -**
   We are permitted to use or disclose your health information to others in order to provide and plan proper medical care for you.

2. **For Payment -**
   We are permitted to disclose health information about your treatment and services in order to submit bills for the care and services you received and to collect payment from you, your insurance company, or a third party payer.

3. **For Health Care Operation -**
   We are permitted to use your health information to assess the care and the outcome in your case and others like it, in order to assure the highest quality of care for our patients. With this consent, Pinke Eye Center may call my home (or alternative location) and leave a message on voicemail or via e-mail in reference to any items that assist the practice in carrying out treatment, payment, or health care operations (such as appointment reminders, insurance items, laboratory results, clinical care questions, and so forth).

I understand your Notice to Privacy Practices containing a more complete description of the uses and disclosures of my PHI is available to me. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact Pinke Eye Center at any time to obtain a current copy of the Notice of Privacy Practices. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Pinke Eye Center may decline to provide treatment to me.

Signature of Patient or Guarantor	Date
Print Patient or Guarantor's Name	

Also, I AUTHORIZE / DO NOT AUTHORIZE (circle one) Pinke Eye Center to release my protected health information to family members (please specify below).

My protected health information may be released to: _____

Pinke Eye Center Use Only

I attempted to obtain the signature of the patient or legal guardian in acceptance of the Notice of Privacy Practices Acknowledgement but was unable to do so as documented below.

Date: Initials: Reason: