WELCOME TO OUR OFFICE | Gene Harrison, O.D. | Gary Few, O.D

Date: ___________________________

Last ______________________________First ______________________________Nickname ____________

DOB: ___ /____/______ Age: _______ Social Security Number _______-______-_______ Sex: M F

Street ____City ________________ State ____Zip ______

Phone: _______________________________ Cell: ________________________________

Legal Guardian or Spouse: ____

Email Address: ____

Pharmacy Name: ________________________________ Pharmacy Phone: _____________________________

Primary Physician: ________________________________

Physician Phone: _____________________________ Physician Fax: _____________________________

<u>Insurance Information:</u>

Vision Insurance: ____

Subscriber Name: ____

Subscriber SSN: ____

Subscriber DOB: ____

Primary Medical Insurance:

Subscriber Name: ____

Subscriber SSN: ____

Subscriber DOB: ____

Contract Number: ____

PAST MEDICAL CONDITIONS

☐ None	☐ Disease caused by COVID-19	☐ Hypothyroidism
☐ Anxiety	☐ Elevated Blood Pressure	☐ Inflammatory Disease of Liver
☐ Arthritis	☐ End-stage Renal Disease	☐ Leukemia
☐ Asthma	☐ Epilepsy	☐ Malignant Lymphoma
☐ Atrial Fibrillation	☐ GERD	☐ Malignant Tumor of Breast
☐ Benign Prostatic Hyperplasia	☐ Hypertension	☐ Malignant Tumor of Colon
☐ Cerebrovascular/Stroke	☐ Hearing Loss	☐ Malignant Tumor of Lung
☐ Chronic Obstructive Lung Disease	☐ HIV Infection	☐ Malignant Tumor of Prostate
☐ Coronary Arteriosclerosis	☐ Hypercholesterolemia	☐ Radiation Therapy Treatment Management
☐ Depression	☐ Hyperthyroidism	☐ Transplantation of Bone Marrow
☐ Diabetes	Other: ____	

OCULAR HISTORY

☐ None	☐ Keratoconus
☐ Allergic Conjunctivitis	☐ Ocular Hypertension (Eye) Right/Left/Both
☐ Blepharitis	☐ Ophthalmic Migraine
☐ Cataract (Eye) Right/Left/ Both	☐ Pseudoexfoliation
☐ Contact Lenses	☐ Retinal Tear/Detachment (Eye) Right/Left/Both
☐ Corneal Dystrophy (Eye) Right/Left/Both	☐ Strabismus/Eye Turn
☐ Diabetic Retinopathy	☐ Posterior Vitreous Detachment (Eye) Right/Left/Both
☐ Dry Eyes	☐ Vitreous Floaters (Eye) Right/Left/Both
☐ Glaucoma (Eye) Right/Left/Both	☐ Wears Glasses
☐ Macular Degeneration – Wet/Dry	
☐ Other: ____	

OCULAR SURGERY HISTORY

☐ Blepharoplasty (Eye) Right/Left/Both	☐ PRK (Eye) Right/Left/Both
☐ Cataract Surgery (Eye) Right/Left/Both	☐ Ptosis Repair (Eye) Right/Left/Both
☐ Corneal Transplant (Eye) Right/Left/Both	☐ Punctual Plugs (Eye) Right/Left/Both
☐ DSAK (Eye) Right/Left/Both	☐ Retinal Laser (Eye) Right/Left/Both
☐ Eye Muscle Surgery	☐ Trabeculectomy (Eye) Right/Left/Both
☐ Intravitreal Injections (Eye) Right/Left/Both	☐ Tube Shunt (Eye) Right/Left/Both
☐ LASIK (Eye) Right/Left/Both	☐ YAG Capsulotomy (Eye) Right/Left/Both
☐ Nystagmus	
☐ Other: ____	

CURRENT MEDICATIONS

____
____
____
____

MEDICATION ALLERGIES

____
____
____
____

SOCIAL HISTORY

DO YOU DRINK ALCOHOL?	YES/NO	HOW OFTEN?
DO YOU SMOKE TOBACCO?	YES/NO	PACKS PER DAY:

FAMILY HISTORY (Check all that apply)

CONDITION:	RELATIONSHIP:
Blindness	
Cataracts	
Corneal Problems	
Glaucoma	
Lazy Eye	
Macular Degeneration	
Retinal Problems	
Diabetes	
Heart Disease	

HIPPA ACKNOWLEDGEMENT OF RECEIPT

***NOTE: If under the age of 18, parent or legal guardian MUST sign**

I acknowledge that I have received a copy of Dr. Harrison/Dr. Few O.D., Notice of Privacy Practices

Date: _______________________

Patient Name: _________________________________ Patient Signature: ___________________________________

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with ____ and assign directly to Dr. Harrison and Dr. Few all insurance benefits. 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. Certain routine services and/or materials that we feel are necessary for good health may not be covered by your insurance. You will be expected to pay for those services and/or materials in full. Should my account become delinquent and require services of a collection agency or an attorney, I will pay reasonable collection fees, attorney fees, and all court costs for collection. I have read the above policies and agree as indicated by my signature.

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PATIENT OR RESPONSIBLE PARTY DATE

Financial Policy

We provide the best possible care and service. Understanding of our financial policies is an essential element of care and treatment. To assist, we present the following financial policy. If you have any questions, please do not hesitate to discuss them with any member of our staff.

Insurance Coverage

It is your responsibility to provide our office with accurate information for billing your insurance plan properly at the time of service. It is also your responsibility to know whether your visit with us is covered by your insurance plan fully, partially, or not at all and whether your plan requires a referral from your primary physician before your visit. For example, you may be covered under your primary healthcare plan for additional vision care services under a different carrier. It is your responsibility to know whether you have this separate coverage. If at the time of service, you only notify us of your primary healthcare plan and later make us aware of additional coverage under another plan, you will be responsible for all charges. We will gladly provide you with an itemized receipt to submit to your insurance for reimbursement. Information of this type is 100% accurate only if you obtain it directly from your health plan, not from our office staff. In the event you do not confirm this information and the insurer refuses full or partial payment, you will be held personally responsible for the cost of the services provided.
Initial _______

Routine and Medical Eye Exams

Our office participates with certain vision plans for "routine eye exams." A routine eye exam is, by definition, a "regular check-up" for someone with no eye problems. If the doctor detects any medical condition, (dry eyes, floaters, etc.) the exam may become a medical eye exam and will be submitted to your medical insurance. If your insurance plan requires a referral you will need to obtain one for the exam. Due to insurance company regulations, routine and medical exams may not be performed on the same day. If you desire only the routine portion of the exam on your visit, the doctor may ask you to return another day for a medical eye exam.
Please note that some insurance plans consider a routine eye exam to be a non-covered service.
Vision Plan Patients: I have read and understand the above routine eye care policy. Initial _______

Spectacle and Contact Lens Exams

Exam for spectacles and contact lenses are separate exams. If you desire both exams on your visit, you will be charged an evaluation fee for a contact lens exam. We require this fee to be paid at the same time of service.
Initial _______

Amounts Due from the Patient

We gladly accept cash, personal checks, Care Credit, and Visa or MasterCard. Insurance co-payments will be collected at the time of service. If we do not participate with your insurance plan, you are to provide payment in full at the time of service. We will provide you with an itemized statement of services and amounts paid which you may submit to your insurance. The insurance is then responsible for reimbursing you. If using insurance, we will make every effort to collect full and accurate fees specific to your plan. However, if there is a fee that your insurance charges and we did not collect it at the time the order was placed, it must be paid in full before glasses and/or contacts will be dispensed. Initial _______

Amounts Determined "Not Covered"

In the event a health plan determines a service of ours to be "not covered," you will then be responsible for the complete charge. An important example of this is our charge for checking eyes for changes in eyeglass prescription and/or contact lens prescription (a procedure called refraction.) We charge for this service and many insurances, including Medicare, deem this service "not covered." If we check your eyes for a change in glasses, you may be personally responsible for this charge. If you do not desire a refraction, please inform our office staff. Please note that some insurance plans consider a routine eye exam to be non- covered service.
Initial _______

I have read and understand the financial policies of Vision Source – Eyes on Main and also understand that Vision Source – Eyes on Main reserves the right to change any and all fees at any time.

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Signature of Patient (or responsible party if patient is a minor)   Date