Patient Registration

Name: _____ Birth Date: _____

Address: _____Email: _____

City/State/Zip: _____ Phone: _____

Social Security #: _____ Gender: _____ Marital Status: _____

Employer: _____ Work Phone: _____

Guarantor/Spouse/Parent: _____ Relationship: _____

Address/Phone#/Social Security#: _____

Primary Care Physician: _____

Referring Physician: _____

Please list two emergency contacts (**not residing in the same house):**

Name/Relationship/Telephone: _____

Name/Relationship/Telephone: _____

Primary Medical Insurance/Subscriber: _____

Policy #: _____ Group #: _____

Secondary Medical Insurance/Subscriber: _____

Policy #: _____ Group #: _____

Vision Insurance/Subscriber: _____

Policy #: _____ Group #: _____

If your insurance requires authorization/referrals, it is your responsibility to have it at the time of your visit or you will be responsible for the charge.

I, the undersigned, have insurance coverage as noted above and assign directly to Delaware Eye Clinics all medical benefits. I authorize release of medical information to insurance companies and other physicians as is necessary for filing medical claims or for consultations. I authorize payment of medical claims to the provider. **I understand that I am financially responsible for all charges not covered by my insurance.** I authorize the use of this signature on all my insurance submissions. If I have Medicare, I request that payment of authorized Medicare benefits be made on my behalf to Delaware Eye Clinics for any services furnished to me by my physician or supplier. I authorize any holder of medical financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____

Name:_____

REFRACTION STATEMENT

A *refraction* is a screening test that determines whether you need glasses or whether your current glasses prescription needs to be changed. This helps us determine your best possible vision and most importantly, if your vision cannot be corrected with glasses, refraction can determine whether an underlying eye disease is the cause for your decreased vision.

If today's refraction is done for the purpose of prescribing new glasses, the refraction charge of $40.00 will not be covered by most insurance companies. Your insurance company may pay this charge if your health care coverage includes a vision plan. You will be expected to pay this charge when you check out today, and then you must submit your receipt to your insurance company for possible reimbursement. Please do not ask us to bill you for this amount.

Since we don't want to present you with any hidden charges, we will give you a prescription for new glasses only at your request. Please sign this statement below if you have read and understand the definition & purpose of a refraction.

_____ _____

Signature *Date*

Delaware Eye Clinics
28322 Lewes-Georgetown Highway
Milton, DE 19968

Financial Policy for Billing & Collection

Payment Policy
Thank you for choosing us as your eye health provider. We are committed to providing you with quality and affordable eye care. Because some of our patients have questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy, Please read it, ask us any questions you may have and sign it in the space provided. A copy will be provided to you upon request.

1. **Insurance:** We participate with most insurance plans, including, Medicare and Medicaid and also the CHAPS program. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan that we do business with, but you do not have a current insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility**. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments coinsurance and deductibles: All co-pays** must **be paid at the time of EACH visit.** This arrangement is part of your contract with your insurance company. Failure on our part to collect co-pays, coinsurance and deductibles from patients is considered fraud. Please help us in upholding the law by paying your co-payment at each visit**. YOUR COPAY WILL NOT BE BILLED TO YOU.** Coinsurance and deductible amounts are your responsibility and will be billed to you after we receive the explanation of benefits from your insurance company.

3. **Self-pay patients:** All self-pay patients are required to pay the **FULL** amount of the day's charges at the time of the office visit**.**

4. **Non-covered services:** Please be aware that some, perhaps all, of the services you receive MAY be non- covered, or deemed experimental or investigational, or not considered reasonable or necessary by Medicare or other insurances. By signing this policy document you acknowledge that **you are responsible for payment of these services.**

5. **Proof of insurance:** All patients MUST complete our patient information form before being seen by the doctor. We must obtain a copy of your driver's license, and current, valid insurance card to provide proof of insurance. **If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for any charges incurred if the information provided is incorrect or not up to date including denied claims due to terminated coverage, exhausted auto benefits, denied workers' compensation claims or no insurance coverage.**

6. **Claims Submission:** We will submit your claims and assist you in any way we reasonably can to help you get your claims paid. **Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Your failure to respond to insurance carrier correspondence or to coordination of benefits inquiries will result in the balance of the claim becoming your responsibility.** Please be aware that the balance of your claim is your responsibility whether

7. **Coverage Changes:** If your insurance changes, please notify us before your next visit, so that we can make the appropriate changes to help you receive the maximum benefits. If your insurance company does not pay the claim within 45 days, the balance will automatically be billed to you. We will notify you of non-payment so that we can get your assistance in getting the claims paid. Most insurance companies have imposed "timely filing" deadlines that possibly could impact payment on your account. Some deadlines are as early as 60 days from the date of service. **If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for any charges incurred if the information provided is incorrect or not up to date.**

8. **Returned Checks:** For ALL returned checks there will be a **$45.00** processing fee (which is the fee we incur from the bank for your returned check) added to the amount of the check and this will be your responsibility to pay in full by cash, credit card or money order within 72 hours of the date of notification. From this point on, we will not accept a personal check from you.

9. **Insurance Referrals:** Some insurances require a referral from your Primary Care Physician. If your insurance requires a referral, it would be written in your contract with your insurance company. **It is your responsibility to obtain the referral, PRIOR to your appointment. You can not be seen without the referral and your appointment will be rescheduled. In addition, due to scheduling purposes we can not wait for you to make the call when you arrive at the office and we will not call your PCP for you.** If the insurance company decides not to pay for your claims due to a missing referral, you will be responsible for the denied claim.

10. **Non Payment (patient):** If your account is over 90 days past due, you will receive a letter stating that you have 15 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated and documented in the form of a payment plan. Please be aware that if a balance remains unpaid, we will refer your account to a collection agency and you will be discharged from the practice until your account is paid in full. In that case, you will have 30 days to find another physician, and during that time, your specific doctor at Delaware Eye Clinics will only be able to see you on an emergency basis, which will be determined by our office**. In addition, you will be responsible for all costs associated with the collection of your balance including all collection agency fees and attorney's costs.**

11. **Missed appointments:** Our policy is to charge for missed appointments, not cancelled within 24 hours of your appointment. **For each missed appointment, there will be a $45.00 fee.** These charges will be your responsibility and billed directly to you. **Additionally, if you miss 3 appointments, you will no longer be able to receive any services at our practice.** Please help us serve you better by keeping your regularly scheduled appointment.

    Our practice is committed to providing the best eye care possible to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

    I have read and understand the financial policy and agree to abide fully by its guidelines:

    _____ Date: _____
    Signature of patient or responsible party

    _____
    Please print your name legibly

Delaware Eye Clinics
28322 Lewes-Georgetown Highway
Milton, DE 19968

I, _____ give my permission for the following people to have copies or access to my Protected Health Information (PHI) (information from my medical records at Delaware Eye Clinics)

Spouse/Partner: _____

Phone _____

Parent /Legal Guardian: _____
(Required for patients under the age of 18 years old)
Phone : _____

Primary Care Physician: _____

Phone: _____

Other: _____

Phone: _____

My Emergency Contact Person: _____

Relationship: _____

Phone: _____

If any other medical provider contacts Delaware Eye Clinics pertaining to my medical care I give my permission for Delaware Eye Clinics to discuss and/or release to them any and all medical records which may be beneficial for my health care.

_____ _____
Patient Signature Date

_____
Parent/Legal Guardian (if patient is under 18 years of age)

*This authorization shall be valid for 2 years from the date signed unless otherwise noted:
Expiration date:_____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand Delaware Eye Clinics's *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that Delaware Eye Clinics may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of Delaware Eye Clinics's *Notice of Privacy Practices* by submitting a request in writing for a current copy of Delaware Eye Clinics's *Notice of Privacy Practices*.

_____
Printed Patient Name

_____ _____
Patient Signature Date

If completed by patient's personal representative, please print name and sign below.

_____ _____
Printed Patient Personal Representative Name Relationship to Patient

_____ _____
Patient Personal Representative Signature Date

For Delaware Eye Clinics Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

Delaware Eye Clinics made a good faith effort to obtain patient's written acknowledgement of the *Notice of Privacy Practices* but was unable to do so for the reasons documented below:

- ☐ Patient or patient's personal representative refused to sign
- ☐ Patient or patient's personal representative unable to sign
- ☐ Other_____

_____
Employee Name (printed)

_____ _____
Employee Signature Date

Name: _____ **Date:** _____

Please answer all questions to the best of your ability and return to the technician or front desk staff.

Demographic Data

Ethnicity: Hispanic or Latino: ☐ Yes ☐ No
Race: ☐ American Indian ☐ Asian ☐ African American ☐ Native Hawaiian ☐ White ☐ Other
Add'l Race: ☐ None ☐ American Indian ☐ Asian ☐ African American ☐ Native Hawaiian ☐ White
Do you have Diabetes? ☐ Yes ☐ No
If female, are you pregnant? ☐ Yes ☐ No If Yes, were you diabetic before pregnancy? ☐ Yes ☐ No

Current Medications

Please list all medications that you are currently taking.

Medications	Dosage & Frequency	Reason

Pharmacy/City/Phone Number: _____

Allergies

Please list all of the medications and substances that you are allergic to, specify the type of reaction & circle its severity. If you are unaware of any, please check: ☐ NO KNOWN ALLERGIES

Allergies	Reaction	Severity
		Mild – Moderate - Severe
		Mild – Moderate - Severe
		Mild – Moderate - Severe

Social History

Habits/Addictions	Yes	No	How Much (per Day/Week)
Beer/Wine/Liquor			
Cigarettes/Cigar/Tobacco			
Drugs: (Specify)			

Reason for exam: _____

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Past Medical History	Yes	No	Year	Complications	Comments
Stroke					
Neurological Disorder					
Tuberculosis					
Diabetes					
Cancer					
Heart Disease					
Kidney Disease					
Skin Disease					
Previous Surgery					

Eye History: (surgery, trauma, etc): _____

Family History of Eye Disease: Glaucoma: ☐ Yes ☐ No
Macular Degeneration: ☐ Yes ☐ No
Have you ever considered LASIK Surgery (vision correction surgery)? ☐ Yes ☐ No

Name_____ DOB: _____ Date: _____

Please check any of the items below that apply to your general health over the last six months:

General:
- ☐ Weakness
- ☐ Tiredness
- ☐ Lack of Appetite
- ☐ Excessive weight loss
- ☐ Excessive weight gain
- ☐ Chills
- ☐ Fever/night sweats
- ☐ Difficulty sleeping
- ☐ None

Skin:
- ☐ Dryness, itching or rash
- ☐ Change in skin color
- ☐ Nail changes
- ☐ None

Eyes:
- ☐ Decreased ability to see
- ☐ Blurred vision
- ☐ Spots in your vision
- ☐ Pain in or around your eyes
- ☐ Flashes of light in your vision
- ☐ Double vision
- ☐ Discharge from your eyes

Ears, Nose, Mouth, Throat:
- ☐ Sinus problems
- ☐ Sore throat
- ☐ None

Respiratory:
- ☐ Dry Cough
- ☐ Wheezing
- ☐ Shortness of Breath with exercise
- ☐ None

Cardiovascular:
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Swelling of legs
- ☐ None

Gastrointestinal:
- ☐ Nausea/vomiting
- ☐ Food intolerance
- ☐ Diarrhea/constipation
- ☐ Abdominal pain
- ☐ None

Urinary:
- ☐ Pain or discomfort on urination
- ☐ Frequent urination
- ☐ None

Musculoskeletal:
- ☐ Painful joints
- ☐ Swelling of joints
- ☐ Redness of joints
- ☐ Stiffness of joints
- ☐ Back pain
- ☐ None

Neurologic:
- ☐ Difficulty going to sleep
- ☐ Difficulty staying a sleep
- ☐ Early morning awakening
- ☐ Headaches
- ☐ Blackouts
- ☐ Difficulty with memory of past events
- ☐ Difficulty with memory of recent events
- ☐ Loss of sensation
- ☐ Loss of balance or coordination
- ☐ None

Endocrine:
- ☐ Goiter
- ☐ Heat/cold intolerance
- ☐ Trembling of the hands
- ☐ None

Hemato/Lymphatic:
- ☐ Swollen lymph nodes
- ☐ Bleeding tendency
- ☐ None

Psychiatric:
- ☐ Nervousness
- ☐ Depression
- ☐ None

- ☐ **NONE OF THE ABOVE**

Reviewed by: _____

Date: _____