20/20 Optometric Eye Care
Patient Information

Today's Date: _____ Referred By: _____

Patient Information:

First Name: _____ Last Name: _____

Address: _____ Apt # _____

City: _____ State _____ Zip Code: _____

Home Phone: (_____) _____ Cell Phone (_____) _____

____ check here if you would like to opt in for text message notifications

Date of Birth: _____/_____/_____ Age: _____ Sex: **M F**

Social Security Number: _____- _____ - _____

E-mail: _____@ _____

____ check here if you would like to opt in for email notifications

Driver's License Number: _____ Exp _____/_____/_____ Issue State _____

Married Legally Separated Single Widowed Minor Divorced Domestic Partner

Insurance Information:

Medical Insurance Plan: VSP Eye Med Spectera Davis MES Care Credit Flex Spending

Other: _____

Primary Insured's Name: _____

Primary Insured's DOB: _____/_____/_____

Primary Insured's Soc. Sec# _____-_____-_____

Primary Employed with (name of company):_____

Relation to Patient: _____

Group Number/ Member Number/ ID Number _____

Provider's Phone Number (_____) _____

Primary Care Physician: _____ Phone Number _____

Medical Insurance Provider: _____

Group Number/ Member Number/ ID Number _____

Provider's Phone Number (_____) _____

Employment History of Patient:

Employed By:_____ Occupation:_____

Business Address:_____ Suite # _____

City: _____ State _____ Zip Code: _____

Business Phone: _____ Business Fax:_____

20/20 Optometric Eye Care
Health Questionnaire

Name:_____**Age:** _____

Emergency Contact:

Name of Person: _____ Relationship: _____

Address: _____ Apt # _____

City: _____ State_____ Zip Code: _____

Home Phone: _____ Alternate Phone: _____

Do you have?
(Place a check in the box near any health problems you may have)

_____**Diabetes**	_____ **High Blood Pressure**	_____ **Rheumatoid Arthritis**
_____**Asthma**	_____ **Sjogren's**	_____ **Colitis**
_____**Psoriasis**	_____ **Systemic Lupus**	_____ **Crohn's Disease**
_____**Depression**	_____ **Auto Immune Disease**	
_____ **Herpes**	_____**Thyroid Disease**	

Do you have any other medical conditions?_____

Are you Pregnant? **Y** **N** Nursing? **Y** **N**

Have you seen any **FLASHES** or **FLOATERS** in your vision? **Y** **N** Circle which one**: Flashes** **Floaters**

Have your pupils ever been dilated? **Yes** **No** When:_____

Have you had any eye surgery? **Yes** **No** When: _____

List health/eye **medication/vitamins/eye drops**? _____

List medication **Allergies**_____

Are you wearing contact lenses now? **Y** **N** If yes, what kind? **Hard** (RGP) or **Soft** ?

What is the **BRAND** name of the **SOFT** contact lens? _____

When did you last wear your contact lenses?_____

Do you sleep with your contact lenses on? **Y** **N**

What type of cleaning solution are you using? _____

How old is the prescription in your glasses? _____ Contacts? _____

I agree to pay in full for services rendered or materials purchased in case my insurance company denies coverage. I authorize the payment of medical benefits to the physician or supplier for the services rendered. I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits to the party who accepts assignment.

Patient's Signature: _____ **Date:** _____

Parent's Signature *(If Under age 18) _____ **Date:** _____

HIPAA

Privacy Practices Acknowledgment & Authorization to Contact Patient/Record of Disclosures

I have read Apple Optometry's Notice of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state law. I have been provided an opportunity to review the notice and I fully understand it. I request the following restriction(s) concerning the use of my personal medical information **(Please List ALL that applies):**

_____

_____

I understand that Apple Optometry is not required to agree to the restrictions requested. Further, I permit a copy of this authorization to be used in place of the original.

The HIPAA Privacy rule gives patients the right to request a restriction on uses and disclosures of their protected health information. The patient is also provided the right to request confidential communication or that a communication of the protected health information to be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner **(Check all that applies):**

- o Home Telephone Number: (_____) _____
- o OK to leave message with detailed information
- o Leave a message with call back number only
- o Cell Phone Number: (_____) _____
- o OK to leave message with detailed information
- o Leave a message with call back number only
- o Opt – In for Text messaging _____(int) msg and data rates may apply depending on your carrier

- o Work Telephone Number: (_____) _____
- o OK to leave message with detailed information
- o Leave a message with call back number only

Written Communication

- o E-mail address:_____

[You can elect

- o OK to mail to my home address
- o OK to mail to my work/office address
- o OK to fax to: _____

You and we agree to submit any dispute arising under this agreement, except a dispute alleging criminal violations, to arbitration in accordance with the Uniform Rules for Binding Arbitration of the Better Business Bureau of the Southland (published online at www.labb.org) in effect at the time of initiation of arbitration. A volunteer arbitrator will render a decision based on fairness, not necessarily upon legal principles, but it will be final and binding on both of us. Judgment on the decision may be entered in any court having jurisdiction. You will not have to pay anything for the arbitration.

This Agreement to Arbitrate affects important legal rights. Neither of us will be able to go to court for disputes once we agree in advance to arbitrate. And neither of us will be committed by the terms of this agreement to arbitrate unless this clause is initialed or unless your signature on this contract as a whole immediately follows this clause. Further information about BBB arbitration may be obtained by calling the Better Business Bureau in Colton at (909)825-0490. _____

(Initials of Customer)

Print Patient Name: _____ **Date:** _____

Patient Signature:_____ **Date:** _____

Parent Signature: _____ **Date:** _____

*(If under 18 years of age)

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals as needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, Amex, cash, or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay for the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will require you to pay the **copay/coinsurance/deductible at the time of service**. If you have a **DEDUCTIBLE** or **COINSURANCE,** you **WILL** be financially responsible for all the services you receive, as your insurance company **WILL NOT** pay us for the services rendered, until you meet your total annual deductible and/or coinsurance. If you cannot pay the deductible or coinsurance at the time of service, we will bill you if arrangements are made, however co-pays are **always** due at the time of service if you do not pay your co-pay at the time of service there will be a $25.00 service fee in addition to all other balances due.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify the benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require prepayment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due to this office.

· There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party _____ Date: _____.
Witness Signature: _____ Date: _____
Printed Name of Witness: _____