Welcome to Our Office

The Doctors and staff are pleased to welcome you to U & M Family Eyecare P.C. Please take a few minutes to fill out this form as completely as you can. If you have any questions, it will be our pleasure to assist you. We look forward to working with you in maintaining your visual health.

Patient Name: _____ **Birth Date** _____ **Age** _____ ☐ **M** ☐ **F**

Mailing Address _____ **Apt #**_____ **City** _____ **State**_____ **Zip**_____

Home Phone _____ **Work #** _____ **Cell #** _____ **Text?** ☐ **Y** ☐ **N**

E-Mail Address_____ **Communication Preference:** ☐ **Phone** ☐ **Postal** ☐ **Email**

Race_____ **Guardian (if patient is a minor)**_____ **Relation to the patient**_____

REASON FOR VISITING OUR OFFICE TODAY _____

Blurred at: ☐ Distance ☐ Near ☐ Night Vision ☐ Eye Strain ☐ Dry Eyes ☐ Floaters ☐ Light Sensitivity ☐ Headaches ☐ Eye Pain

Primary Physician Name:_____ **Phone#**_____

REVIEW OF SYSTEMS (check all that apply) **Date of last eye exam (approximately)** _____

	Self	Family	Relation	Maternal/Paternal		Self	Family	Relation	Maternal/Paternal
Macular Deg.	☐	☐	_____	M / P	Hypertension	☐	☐	_____	M / P
Cataracts	☐	☐	_____	M / P	Cholesterol	☐	☐	_____	M / P
Glaucoma	☐	☐	_____	M / P	Heart Disease	☐	☐	_____	M / P
Retinal Det.	☐	☐	_____	M / P	Thyroid	☐	☐	_____	M / P
Diabetes	☐	☐	_____	M / P	Arthritis	☐	☐	_____	M / P
Cancer	☐	☐	_____	M / P	Stroke	☐	☐	_____	M / P

Have you had an Eye Injury/Surgery? ☐ Y ☐ N Are you currently pregnant? ☐ Y ☐ N Any Tobacco Use? ☐ Y ☐ N

Are you currently taking any medication?: ☐ Y ☐ N If yes, list the medication:_____

_____

Are you allergic to any medication? ☐ Y ☐ N If yes, list the medication: _____

_____

Insurance Information: Please provide your medical and vision insurance card to the doctor's assistant.

I am not filing vision or medical insurance _____(please check if this applies)

Primary Member's Name: _____ **Primary Member's DOB:**_____ **SS#:** _____
Employer _____ **Patient's Relation to member:** ☐ **Self** ☐ **Spouse** ☐ **Child**

Medical Ins:_____	**Vision Ins:**_____	**Secondary Ins:**_____
ID #: _____	**ID #:** _____	**ID #:** _____

By signing below, I acknowledge that:
The information I have provided is accurate to the best of my knowledge.

- I may request a copy of U & M Family Eyecare, P.C. Notice of Privacy Practices (effective April 14, 2003; Amended September 2013), although it is posted in the office.
- I understand contact lens fitting fees ($40-$60) are due at the time of service and may require a follow-up visit which may be subject to additional fees if the patient fails to return within 30 days of the initial visit.
- I understand that U & M Family Eyecare requires a 24 hour notice for any appointment cancellations. I f I fail to give a 24 hour notice I will be responsible for the $20 no show fee.
- I am financially responsible for all charges incurred today, including contact lens fees and I understand that professional fees are non refundable.
- By signing below, I understand and agree to allow U & M Family Eyecare, P.C. to file my claim.
- By signing below, I authorize U & M Family Eyecare, P.C. to communicate information, to me, via SMS (text message), automated phone calls and email. Info could include, but not limited to, recalls and appointment reminders.

_____ _____

Patient or Guardian Signature **Date**

Please read and understand the following:

U & M Family Eyecare will be happy to file your Insurance Claim for your eye examination. Your claim will be filed to your **vision** insurance if it is **routine** examination. Your claim will be filed to your **medical** insurance if there is a **medical diagnosis**.

- **Routine Eye Exams are defined as:** An examination of the visual system void of any medical eye conditions such as diabetes, glaucoma, macular degeneration, cataracts, allergies or contact lens complications etc.
- **Medical Insurances DO NOT cover routine eye examinations unless there is a specific Vision Rider that states otherwise.**
- Your medical insurance **WILL** cover a **comprehensive MEDICAL** examination **IF** there is a **MEDICAL** diagnosis.
- **Our Comprehensive Medical Eye Examination fees are based on Medicare fee guidelines, which are higher than that of a basic routine eye exam fees.** Ask our staff if you have any questions regarding your fees, before being seen.
- Medical Insurance **DOES NOT** cover refraction's for which there is a $25.00 fee.
- Medical Insurance **DOES NOT** pay for contact lens fittings or optional screenings offered.
- **Medicare patients** will be required to pay **20%** of the examination cost unless you have supplemental insurance which will cover the balance.
- **Medical Insurance** holders will be required to pay appropriate co-pays as agreed upon by your insurance carrier. Please be aware that you must meet your deductible **FIRST before** your medical insurance will pay for services rendered. You will be sent a bill for the balance due if you have not met your deductible.
- If your medical or vision insurance does not pay for any services rendered, **you will ultimately be responsible for all monies owed. If you fail to pay your bill it will be sent to collections. You agree that you will be responsible for any legal fees associated with paying your bill.**
- **If you are unable to provide your insurance information at the time of service, you will be responsible for all monies owed.** We can not file a claim, to your insurance, after the fact. You may choose to reschedule your appointment when you have your insurance available or pay, in full, for all services rendered.
- By signing below, I understand and agree with all said statements and allow us to file your claim.
- By signing below, I authorize the release of any medical or other information necessary to process this claim.
- I authorize payment of medical benefits of the undersigned physician or group for services rendered.

_____ _____

Patient or Guardian Signature **Date**

DILATION

In order to thoroughly examine the internal structure of the eye, it is necessary to enlarge the pupil of the eye (dilation). This allows the doctor to observe the peripheral area of the retina that would otherwise be hidden from view. You may experience blurred vision for reading. Your distance vision will usually not be blurred, but it may seem a little distorted and it may be more sensitive to light. You will be able to drive after having your eyes dilated, but you should use extra caution. This also applies to all other physical activities such as walking, climbing stairs or curbs, etc.
There is NO additional charge for dilation.

_____ **Yes**, I **DO** want the Dilation. _____ **No,** I **DO NOT** want the Dilation

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RETINAL IMAGING

A new technologically advanced camera now allows us the ability to take pictures of the back of the eye (retina, optic nerve, and macula) to screen for problems that can affect your vision. With this technology we are able to diagnose eye conditions such as glaucoma, macular degeneration, diabetic and hypertensive retinopathy as well as Tumors from one visit to the next. **This test is highly recommended on a yearly basis. There is an additional fee of $30.00 for the screening version of this procedure. Should extensive photography and reporting be required to document eye pathology, your insurance may cover additional cost.**

VISUAL FIELD TEST FOR DETECTION OF VISUAL DISORDERS

Our new OCULUS VISUAL FIELD ANALYZER utilizes computer technology to electronically measure retinal function and contrast sensitivity. This test can also assist us in early detection of many disorders including brain tumors, glaucoma, diabetic retinopathy and retinal detachments. **This test is highly recommended on a yearly basis. There is an additional fee of $15.00 for the screening version of this procedure. Should extensive photography and reporting be required to document eye pathology, your insurance may cover additional cost.**

Please check below:

_____ I would like to have the Retinal Imaging done

_____ I would like to have the Visual Field Examination done

_____ **I would like both (we are able to combine testing for $40.00-best value)**

_____ **I would prefer neither test at this time**

OPTICAL COHERENCE TOMOGRAPHY (OCT)

Optical Coherence Tomography or **OCT** is a sophisticated scanning system that produces highly detailed images of the **retina** and **optic nerve**. It is similar to an MRI or ultrasound of the back of the eye. OCT measures the retinal nerve fiber layer thickness in glaucoma and other diseases of the optic nerve and retina. **This test is highly recommended on a yearly basis. There is an additional fee of $30.00 for the screening version of this procedure. Should extensive photography and reporting be required to document eye pathology, your insurance may cover additional costs.**

_____Yes, I would like to have the OCT Scan _____No, I would not like to have the OCT Scan.

_____ _____

Patient or Guardian Signature **Date**