New Patient Emergent Care Form

Name:____ Date:________________ Date of Birth:___________________________

Address:____Date of Last Eye Exam:___________________________

City:__________________________________State:___________Zip:_______________Last 4 digits of social security#:______________

PHONE: Home:_________________________ Work:_____________________________ Cell:___________________________________

Spouse / Parent or Guardian Name:____Primary Care Physician:___________________

List any medications you are currently taking (prescription and over-the counter)? Including aspirin, vitamins etc.

____

Do you have any allergies to medications? Y or N If YES list here:____

Are you currently pregnant? Y or N Are you nursing? Y or N

Do you use tobacco products? Y or N If so, how much ______________ Years using ______________

Do you use alcohol? Y or N Do you use recreational drugs? Y or N

What is the nature of the problem? ____

Did this occur at your place of employment? Y or N

Which eye? *(Circle One)* RIGHT LEFT BOTH

Has your vision been affected? Y or N If so, how has your vision been affected? BLURRINESS LOSS OF PERIPHERAL VISION

Do you have any matting? Y or N If so, what is the color of discharge? ___________________________________

Do you have any of the following? *(Circle all that apply)*

BURNING ACHING ITCHING REDNESS PAIN WATERING LIGHT SENSITIVITY

SWELLING FOREIGN BODY SENSATION DISCOMFORT

When did you first notice the problem? ____

Have you ever had this problem in the past? ____

What have you been doing for this condition? ____

OVER------------→

HIPPA NOTICE OF PRIVACY:

Signature on File: I authorize Ossian Family Eyecare to release to my insurance companies, the Social Security Administration, Health Care Financing, or agent Medicare or of my supplemental insurance any information needed to determine my insurance coverage, Medicare or supplemental insurance benefits.

I further authorize all insurance companies or agents of Medicare to release to doctors any information needed to resubmit denied or incorrectly paid claims. I authorize Ossian Family Eyecare to file claims with all co-insurance and further authorize and direct my insurance benefits (item 9 of the CMS 1500 form) be made either to me or on my behalf to Ossian Family Eyecare for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to (name of medigap insurer) any information needed to determine these benefits or the benefits payable for related services.

Notice of Payment Policy:

All professional fees, including exam and any additional testing recommended by the doctor, are due and payable the day they are provided. If glasses or contact lenses are included in your fees, 50% is required when ordering and the balance is due at dispensing.

If your fees are covered by a vision plan for which we are participating providers, or by Medicare or Medicaid, any applicable deductibles, Co-payments and non-covered services and/or materials are due and payable on the date of your examination.

A prompt pay agreement is available to patients whose examination fees are not covered by a vision plan or who do not have any type of vision coverage. By signing a prompt payment agreement the patient agrees to the terms of this contact which provide a reduction in our usual and customary examination fee. This agreed upon amount, as determined by the contract, is payable at the time of your initial visit.

I understand that any fees incurred are my responsibility, unless otherwise prohibited by law, regardless of any insurance benefits, and that they are to be paid as stated in the above payment policy. Any collections and/or legal fees are also my responsibility.

Payment will be made by (check one):

______ Self (ask office receptionist for Prompt Payment Agreement/Contract)

______ Insurance (name) ________________________________ Policy #_____________________________________

______ Medicare (#) ____________________________________

______ Medicaid (#) _____________________________________

______ Other ____

*Please indicate your PRIMARY insurance ____

By signing below I acknowledge my responsibility for all of the above. I also acknowledge I was given the option to receive a copy of the

HIPPA Notice of Privacy.

X____Printed Name (Responsible Party or Parent/Guardian)

X____Signature/ or Authorized Party

Date_______________________________