Welcome to Our Office

The Doctors and staff are pleased to welcome you to U & M Family Eyecare P.C. Please 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□

Home Phone: _____ Cell Phone: _____ Email_____

Mailing Address:_____ City:_____ Zip Code:_____

Guardian *(if patient is a minor)*_____Relation to the patient: _____

REASON FOR VISITING OUR OFFICE TODAY:

□ Distance □ Near □ Night Vision □ Eye Strain □ Dry Eyes □ Floaters □ Light Sensitivity □ Headaches □ Eye Pain

Have you had an Eye Injury/Surgery? Y N □ □ *If so type of injury /surgery and date:* _____

Are you currently pregnant? Y N □ □ Any Tobacco Use? Y N □ □

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

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: _____

_____

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 □ □

Insurance Information: Please provide your VISION and MEDICAL insurance cards to our office at each visit.

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

Primary Member's Name: _____ Primary Member's DOB:_____

Primary Member's SS#: _____ Primary Member's Employer:_____

Patient's Relation to primary member: □ Self □ Spouse □ Child

Vision Ins. Name	**Vision Member ID #**
Medical Ins. Name	**Medical Member ID #**
MEDICARE ID #:	**Supplemental Ins Name & ID #:**

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 ($55-$135) 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.
- If an appointment is not canceled 24 hours in advance you may be charged a $20 fee; this fee will not be covered by your insurance company.
- 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.

I have read and agree with this policy.

X Patient or Guardian Signature: _____ Date: _____

Will my visit be billed to my MEDICAL INSURANCE (Medicare, Aetna, Horizon, BCBS, Cigna, etc.) or my VISION PLAN (VSP, Davis, Eyemed, etc.) ?

SHORT EXPLANATION:

Medical Insurance will be used for eye health visits (diabetes, cataract, glaucoma, eye pain, eye injury, etc.). No coverage for glasses, contacts (except medically necessary contacts for diseased eyes) or other similar materials are provided by most medical health plans. Vision Plans are not truly insurance but cover routine exams for glasses, contacts and inspection of the internal and external eye health in a healthy person without known eye disease. You may have coverage for materials.

LONG EXPLANATION:

One of the most challenging billing issues for an eye doctor's office is to determine whether your visit is for a medical reason (diabetes, cataract, glaucoma, eye pain, etc.) or a wellness vision exam to determine your prescription for glasses, contact lenses and screen the health of your eyes to make sure you do not have an eye problem or disease you may not be aware of yet.

Sometimes it is appropriate to schedule separate visits to accommodate both your routine eye care needs (glasses, contacts) and medical eye needs (glaucoma follow up, eye emergencies like injury or red eye, etc.) on different days. As a general rule of thumb, please note medical plans do not cover materials (glasses or contacts) but some may have an annual reimbursement direct to patient. It is the patient's responsibility to know whether they have this benefit and file directly with the medical plan for reimbursement. We will assist with appropriate receipts for submission.

Our goal is to bill appropriately based on the reason for visit. If you call us with an eye problem or sudden change or loss in vision OR another doctor asked you to see us for an exam because you are diabetic or put on medications that can risk your eye health, we will cater the exam to medical eye care and bill your medical insurance the same way any other specialist health care provider would. The patient is responsible for obtaining referrals, copays, deductibles and coinsurance. Rarely, a routine visit must be converted to medical if an incidental and urgent eye problem is discovered during your vision exam (such as very high eye pressure that needs immediate testing and treatment to prevent irreversible vision loss). If you have a vision plan, it is your responsibility to inform our staff at the time of scheduling the appointment so that we may assist you in understanding your benefits. Vision plans are not eye insurance and do not cover medically necessary eye testing. Vision plans assist in discounted fees for contact lenses and glasses. Some plans are better than others. We will help you maximize your savings. In order to do this, you must know your plan and present it ahead of being seen for your exam.

Medicare does not pay for eyeglasses or contact lenses. Medicare patients will be responsible for their refraction fee (if necessary) and their annual deductible (if not met at another doctor's office already for the calendar year).

- If your medical or vision insurance does not pay for any services rendered, you will ultimately be responsible for all monies owed, including co-pays, deductibles and all out of pocket expenses. 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.
- 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 to the undersigned physician or group for services rendered.

I have read and understand the above explanation.

X Patient or Guardian Signature:_____ Date: _____

PHOTO RELEASE FORM

Print Patient Name: _____

Print Parent/Guardian Name: _____

_____ I **DO** give permission for mine or my child's picture to be used by U & M Family Eyecare on their website or any other publication such as Instagram, Facebook, Google etc.

_____ I **DO NOT** give permission for mine or my child's picture to be used by U & M Family Eyecare on their website or any other publication such as Instagram, Facebook, Google etc.

X Patient Signature: _____ Date: _____

X Parent/Legal Guardian Signature: _____ Date: _____

OFFICE/BILLING/COLLECTIONS/CANCELLATION/RESCHEDULE POLICIES

• 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 ($55-$135) 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.
• If you are unable to keep your scheduled appointment, please call our office at least 24 hours prior to your appointment time to notify us. This allows us to offer that time to another patient. If you fail to show up for your appointment or cancel your appointment within 24 hours of your scheduled time, this constitutes a no show and you will receive a $20.00 fee. Patients with five or more no-shows within a one year period will not be allowed to schedule future appointments but may be seen as a work in appointment depending on availability
• Payment for all services is due at the time services are rendered. If, however, arrangements have been made to accept your insurance as payment, we will bill your insurance company directly. In the event the insurance company does not pay, the patient is held solely responsible for the bill. Although we are more than happy to file an insurance claim on your behalf and answer any questions about a specific claim, coverage issues can only be addressed by your employer or group plan administrator. We cannot act as a mediator with the carrier or your employer. 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 information available or pay in full for all services rendered. There are no refunds for services rendered.

• By signing below, I understand that there is no recording of any kind allowed during a patient exam. If an exam is recorded, you will be asked to delete the recording immediately.
• 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.

I have read and agree with this policy.

X Patient or Guardian Signature: _____ Date: _____

DILATION

There is NO additional charge for 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.

I understand the importance and side effects of having my eyes dilated and at this time request to:
Please check below:

___ Yes, I DO want the Dilation ___ No, I DO NOT want the Dilation ___ I Take Responsibility to Reschedule my Dilation

SCREENING TESTS ARE IMPORTANT BECAUSE IT THE BEST WAY TO FIND THE MEDICAL CONDITIONS OR DISEASES AT AN EARLY STAGE WHEN TREATMENT IS FEASIBLE, EASY AND LESS EXPENSIVE. SECONDLY, SCREENING TESTS REVEAL THE RISK FACTOR WHICH IS A HEALTH CONDITION OR A BEHAVIOR THAT PUTS US AT RISK OF DEVELOPING THE DISEASE.
~The Screeners Listed Below Are NOT Covered By Insurance ~

RETINAL IMAGING

A 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 out of pocket 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 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 out of pocket 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 ($30.00)
_____ I would like to have the Visual Field Examination done ($15.00)
_____ I would like both (Combo 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 out of pocket fee of $30.00 for the screening version of this procedure. Should extensive scanning and reporting be required to document eye pathology, your insurance may cover additional costs.

Please check below:

___ Yes, I would like to have the OCT Scan ($30.00 ___ No, I would not like to have the OCT Scan

X Patient or Guardian Signature: _____ Date: _____