PATIENT FORM

JOHNSON EYE CARE

GENERAL INFORMATION

DATE:

Name				Preferred Name:		
Street Address						
City, State, Zip						
Cell Phone						
Home Phone						
Email						
Preferred Contact Method	*Text*	*Cell Phone*	*Home Phone*	*Email*		
Date of Birth						
Male/Female						
Occupation/Employer					*Full Time*	*Part Time*
Marital Status	*Married*	*Single*	*Divorced*	*Legally Separated*	*Widowed*	
Emergency Contact Name				*Relationship:*		
Emergency Contact Phone #						

INSURANCE INFORMATION

Vision Insurance Name						
Vision Insurance Member Name						
Member Last 4 of Social Security #						
Vision Insurance Member ID#						
Vision Insurance Member Date of Birth						
Primary Medical Insurance	*Aetna*	*Blue Cross PPO*	*Humana*	*Medicare*	*United Health Care*	*Other:*
Primary Member Name						
Insurance ID#						
Insurance Policy#/Group ID#						
Primary Member Date of Birth						
Primary Member Last 4 of Social Security #						
Primary Member Employer						
Your Relationship to Primary Member	*Self*	*Spouse*	*Child*	*Other (Please Explain)*		

EYE HISTORY

Date of Last Eye Exam:
Do you currently wear glasses?
Have you ever worn contacts?
Do you currently wear contacts?
Reason for Today's Visit:
Do you require any special accommodations today?

PATIENT FORM

JOHNSON EYE CARE

PATIENT NAME:

Are you currently experiencing any of these eye conditions? Please check all that apply.
☐ Dryness
☐ Tearing
☐ Itching
☐ Loss of Vision
☐ Glare or Light Sensitivity
☐ Double Vision
☐ Flashes
☐ Floaters
☐ Redness
☐ Eye Pain
☐ Distorted Vision/Halos
☐ Cataracts
Do you have a history of eye surgery? Yes / No
If yes, date and type of procedures:
Have you or a family member been diagnosed with any of the following? (Please Circle)
Macular Degeneration Yes No Family
Glaucoma Yes No Family
Current Medications: (Prescription and Over-The-Counter and Dosage)
Please List Any Allergies to Medications:
☐ Current tobacco user - Type/Frequency:
☐ Former tobacco user - Quit Date: Total number of years:

Do you have any of the following conditions? Please check all that apply.
☐ Environmental Allergies
☐ Skin Conditions *Type:*
☐ Hearing Problems
☐ Asthma
☐ Emphysema / COPD
☐ Anxiety / Depression / ADHD
☐ Headaches
☐ Seizures
☐ Multiple Sclerosis
☐ Hypertension
☐ High Cholesterol
☐ Heart Disease
☐ Stroke
☐ Anemia
☐ Joint Pain
☐ Auto Immune Disease *Type:*
☐ Diabetes *Type I / Type II*
☐ Thyroid Abnormalities *Hyper / Hypo*
☐ Cancer *Type:*
☐ Kidney Problems
☐ Gastrointestinal Problems
☐ GERD
☐ AIDS / HIV
☐ Gonorrhea / Syphilis
☐ Hepatitis *Type:*
☐ Pregnant / Nursing
Please list any other health conditions:
☐ Illegal Drug Use *Type:*
☐ Alcohol Use ☐ Less than 1 drink per day ☐ 1 or more drinks per day

Jeffrey A. Johnson, OD
Rebecca A. Schoepke, OD
Katherine S. Delgadillo, OD
Jacie M. Thomas, OD

PATIENT CONSENT FORM

Our notice of Privacy Practices provides information about how we may use or disclose protected health information. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing. However, such a revocation will not be retroactive.

May we phone, email or send a text to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition, billing, or insurance with a member of your family?	YES	NO

If YES, please provide name and relationship of authorized individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

By signing this form, I agree to the terms above. I acknowledge that a copy of Johnson Eye Care's Notice of Privacy Practices was made available to me.

Patient Name: _____ Patient Date of Birth:_____

Patient Signature: _____ Date:_____

(parent/guardian if patient is minor)

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VISION EXAM vs. MEDICAL EXAM

Regular eye examinations are important to maintain your vision for your lifetime. It is important that you be aware of your insurance benefits and how they apply to your visit. We have prepared this form to help you understand how your visit is submitted to your health or vision insurance for today's visit. Benefits may vary based upon the reason for your visit.

Routine Eye Examinations A "routine eye exam" takes place when you come for an eye examination without any underlying medical condition which affects the eye. Vision exams do not cover for management or treatment of medical problems. The doctor screens the eyes for disease and checks your vision. Examples that necessitate your visit being submitted as a vision exam include:

- Basic Eye Exam
- Glasses / Contact Lenses

Medical Eye Examinations Exams for medical care which are for evaluation of a medical related complaint or follow up of an existing condition are examples of an eye examination that would be billed to your medical insurance. Examples that will necessitate your visit being submitted as a medical exam include but may not be limited to:

- Diabetes Mellitus
- Dryness/Redness of Eyes
- Allergies
- Floaters and/or Flashing Lights
- Glaucoma
- Referral From Outside Physicians
- Eye Irritation
- High Risk Medications
- Eye Muscle Imbalance
- Macular Degeneration

The purpose of your visit will determine which insurance benefit will be used. Sometimes this may not be obvious until after your eye doctor sees you. If your doctor determines that your problem falls under the category of a "medical eye examination" your visit may be billed as a medical exam instead of a routine vision exam. Medical eye exams will be subject to co-pays and deductibles according to your medical insurance plan. You will then have the option to pay out of pocket for your refraction (glasses/contact lens prescription) or schedule a return appointment, using your applicable vision insurance. We understand the distinction between medical and vision plans is often confusing and will work with your insurance to minimize out-of-pocket expenses.

Patient Name: _____

Patient Signature: _____ Date:_____
(parent/guardian if patient is minor)

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ACKNOWLEDGEMENTS

Financial Policy

At Johnson Eye Care, it is our mission to provide the best possible eye care. This involves a mutual understanding between patients, doctors, and staff. We encourage you to discuss any questions you may have regarding our payment policy. Our professional services are rendered to you, not the insurance company. Therefore, payment for services is your responsibility. Payment for services is due at the time the services are rendered unless other payment arrangements have been made and approved by our staff. This includes services provided for a patient who is a minor. The presenting parent is responsible. We collect full payment for glasses at time of order and contact lenses at pick up. We gladly accept most forms or payment including: Cash, Check, Credit Cards and CareCredit. We are happy to offer these choices so that you can select a payment option that best fits your needs. Please ask if you would like more information on CareCredit in order to make an informed decision about which payment option you prefer.

We are providers for many medical insurance companies. As a courtesy to you for in network insurance plans, we will bill and receive payment directly from your medical insurance company for covered services. You will be responsible for any remaining balance. We make no claim to know what services your insurance covers. Your insurance policy is a contract between you and your insurance company–we are NOT party to that contract. It is your responsibility alone to know what services may or may not be covered by your insurance. We encourage you to refer to your insurance member services department if you have questions about covered services. Please be aware that some or perhaps all of the services provided may be non-covered services by your insurance. You will be responsible for payment of all non-covered services at the time they are rendered.

Appointments

1.) We value the time you/we have set aside to take care of your eyes. If you are not able to keep an appointment, we request at least 24-hour notice. Patients who do not show up for 3 appointments without notifying us in advance may be assessed a fee.
2.) If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
3.) We strive to minimize any wait time; however, emergencies do occur and some patients may take longer than others. This may affect scheduled visit times. We appreciate your understanding.

(signature required on backside)

PLEASE READ AND SIGN THE FOLLOWING:

1.) I hereby authorize Johnson Eye Care to bill my medical insurance company for services provided, with payment to be made directly to the physician optometrist. I authorize this office to release all information necessary to secure the payment. In the event I receive payment from my insurance company for services rendered in this office; I agree to endorse payment received to the physician optometrist or this office.
2.) In the event Johnson Eye Care is not a participating provider in my health plan, I will be expected to pay for all services rendered and materials received.
3.) I understand and agree that I am directly and fully responsible to the physician optometrist for payment of all charges. I understand that such payment is not contingent on any settlement, judgment, insurance decision, or insurance payment by which I eventually recover said fee. I realize that if my insurance company fails to pay the anticipated balance in full or payment is not made, it is my responsibility to pay the doctor's bill and collection fees, if applicable.
4.) I understand that Medicare specifically does not cover the refraction portion of the eye examination and I am responsible for that fee.

This agreement will remain in effect until revoked by me in writing. I understand and agree to the above:

Patient Name: _____

Patient Signature: _____ Date:_____
(parent/guardian if patient is minor)

A photocopy of this authorization and understanding shall be considered as valid as the original.