Mid-Valley Eyecare

First Name:	**Middle Name:**	**Last Name:**	
Date of Birth:	**Sex:**		**Nickname:**
Address:	**City:**	**State:**	**Zip Code:**
Home Phone:	**Cell Phone:**		**Work Phone:**
Marital Status:	**Email Address:**		
Ethnicity: **Hispanic or Latino** **Not Hispanic or Latino**	**Race (Circle one): -White -American Indian or Alaska native -Asian -Black or African American -Native Hawaiian or Pacific Other Islander -Other Race**		

AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize Mid-Valley Eyecare, doctors and staff; to disclose information regarding my medical treatment and diagnosis and information regarding my financial account with the following designated individuals or organizations. _____ **(Initial)**

Name of person or persons you wish to authorize release of information to._____
You may revoke this right at anytime. _____ **(Initial)** (Another doctor or a Family Member)

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Mid-Valley Eyecare is committed to caring for our patient's complete ocular health. Our patients will receive a **COMPLETE EYE HEALTH EXAMINATION**. Our doctors are trained to diagnose and treat most ocular diseases. _____ **(Initial)**

Routine Vision exams will be filed with a patient's Vision Plan if you have one. A routine exam means there is not a medical diagnosis. Routine diagnosis is myopia (near-sightedness), hyperopia (far-sidedness), astigmatism, and presbyopia. Routine exams now include Optomap, an ultra-wide field retinal imaging that captures more than 80% of your retina, allowing for early detection of many eye conditions and even other diseases (Diabetes, Heart Disease). _____ **(Initial)**

If a **Medical Diagnosis** (cataracts, glaucoma suspect, glaucoma, diabetes, pink eye-conjunctivitis, foreign body, etc.) is determined by the doctor; the patient's exam is no longer routine, but medical. At that time, the doctor may order imaging of the eye. This will be billed to your Health (Medical) Insurance. We request a copy of your medical card in your chart for these reasons.
I have read and understand when my **Vision Plan** will be billed and when my **Medical Insurance** will be billed by Mid-Valley Eyecare. _____ **(Initial)**

Late & No-Show Policy: If you are 10 or more minutes late for your scheduled appointment, we may ask you to reschedule your appointment. If you miss your appointment, without giving 24 hours notice, two or more times, we will not reschedule your appointment. _____ ***(Initial)***

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I, , have read it and understand all of the above information.

_____ _____ _____
Signature of patient or Guarantor Relationship if not patient Date

Name:

To our Valued Patient,

All co-pays, co-insurances and deductibles are due at the time services are rendered. You may receive a bill at a later date as co-pays, co-insurance and deductible amounts are an estimate based on information your insurance company provides and not a guarantee of payment. **All account balances are considered patient responsibility.**

Insurance will be billed as a courtesy for each patient who provides insurance benefit information at time of visit or within 24 hours of appointment.

Authorization:

I authorize the doctor to release any information including diagnosis, records of treatment or examinations rendered to me or my child during the period of such eye care to 3rd party payers and/or health practitioners. I authorize & request my insurance company to pay directly to the eye doctor or group insurance benefits otherwise payable to me. I understand my insurance may pay less than the actual billed amount for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Our experienced billing staff will follow up with your insurance company for 90 days in an attempt to have remaining service balances covered by your insurance company.

If your insurance company has not paid your remaining account balance within that 90 day period the balance remaining on the account will then be turned over to the patient or responsible party. Payment will then be expected within 30 days of billing statement.

If payment is not made on the account by patient or insurance company within 60 days from billing statement date patient will be turned over to our local collection agency.

We look forward to working with you and providing the best eye care for your eye health needs.

Patient /Responsible Party Name: _____

Signature:_____ Date:____/_____/____

HIPAA Policy:

I, , have been presented a copy of the HIPAA privacy act. I have read it and understand the content. I know that at any time I can request my own personal copy of the form.

Patient /Responsible Party Name: _____

Signature:_____ Date:____/_____/____

PATIENT HISTORY AND INFORMATION **Name:** _____

What is the main reason for today's exam? _____

Who is your **Primary Care Physician:** _____

Were you referred to our clinic? If yes, by whom? _____

REVIEW OF SYSTEMS / ***Mark all that apply to YOU below*** (Filled out by O Patient O Family O Staff)

Constitutional

O None Apply
O Developmental Disability
O Weight Loss
O Trauma
O Fatigue
O Other_____

Respiratory

O None Apply
O Cigarette Smoker
O Asthma
O COPD
O Emphysema
O Other_____

Musculoskeletal

O None Apply
O Fibromyalgia
O Osteoarthritis
O Arthritis
O Other_____

Endocrine

O None Apply
O Hormonal Dysfunction
O Diabetes
  O Non-insulin
  O Insulin
  O Last A1C:_____
    Date:_____
O Thyroid Dysfunction
O Other_____

Cardiovascular

O None Apply
O High Cholesterol
O Heart Disease
O High Blood Pressure
O Vascular Disease
O Stroke
O Other_____

Gastrointestinal

O None Apply
O Acid Reflux (GERD)
O Crohn's
O Ulcer
O Digestive
O Other_____

Integumentary

O None Apply
O Psoriasis
O Eczema
O Rosacea
O Other_____

Eye Health

O None Apply
O Cataracts
O Glaucoma
O Macular Degeneration
O Surgery:_____
O Inflammatory Disorders
O Burning
O Redness
O Itch
O Watering
O Blurry Distance
O Blurry Near Vision
O Difficulty Seeing at Night
O Floaters or Spots
O Occasional Dry Eye
O Flashes of Light
O Sun Sensitivity
O Light Sensitivity Indoors
O Lazy Eye
O Headaches Related to Vision

Ears, Nose & Throat

O None Apply
O Upper Respiratory Tract Infection
O Vertigo/Dizziness
O Hoarseness/Speech Difficulty
O Other_____

Genitourinary

O None Apply
O STD
O Kidney ailments
O Other_____

Neurological

O None Apply
O Multiple Sclerosis
O Epilepsy
O Migraines
O Other_____

Psychiatric

O None Apply
O Schizophrenia
O Depression
O Panic Disorder
O Anxiety
O Other_____

Allergic/ Immunologic

O None Apply
O Environmental Allergy
O Lupus
O Rheumatoid Arthritis
O Other_____

Hematologic/ Lymphatic

O None Apply
O Large Volume Blood Loss
O Leukemia
O Anemia
O Cancer:_____
  When:_____
O Other_____

Name:

SOCIAL HISTORY:

Do you:

Smoke? ○ Never ○ Former ○ Current

Drink Alcohol? ○ No ○ Social ○ Daily

Use other substance? ○ Yes ○ No

Height:_____ **Weight:**_____

Do you use a computer? ○ Yes ○No

How many hours/day:_____

FAMILY MEDICAL/EYE HISTORY:

(Check all that apply)

	FATHER	MOTHER	SIBLING
Diabetes	☐	☐	☐
Cataracts	☐	☐	☐
Glaucoma	☐	☐	☐
Macular Degeneration	☐	☐	☐
High Blood Pressure	☐	☐	☐
Heart Disease	☐	☐	☐
Color Blindness	☐	☐	☐
Lazy Eye	☐	☐	☐

Hobbies/Interests? _____

Please note any current medications or eye drops:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Medications Allergies/Sensitivities:

_____
_____
_____

Past Surgeries/Eye Surgeries:

_____
_____
_____

SPECTACLE HISTORY:

Do you currently wear glasses? ○**Yes** ○**No**
Are you interested in new glasses? ○**Yes** ○**No**

CONTACT LENS HISTORY:

Do you currently wear Contact Lenses? ○**Yes** ○**No**
Are you interested in contact lenses? ○**Yes** ○**No**

Rest assured, we want you to succeed with your new eyewear. If after 2 weeks you are having issues with your lenses please come in to see our optician. If they are unable to resolve the issue, we will have you see the Dr. to check your prescription at no charge to you. Due to insurance and lens manufacturing companies, we have 90 days to change your lenses if necessary. It is your responsibility to contact us within that time limit.

INITIAL: _____