

Vestavia Eye Care, P.C.

John A. Essinger, II, O.D., M.S. James D. Fisk, O.D., Ph.D. Calah O. Ray, O.D.

PATIENT INFORMATION

PATIENT NAME _____ GOES BY _____

DR. ___ REV. ___ MR. ___ MASTER ___ MRS. ___ MS. ___ MISS ___

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE: HOME _____ WORK _____ CELL _____ texting ok

E-MAIL ADDRESS _____

MAY WE THANK SOMEONE FOR REFERRING YOU ? _____

MALE/FEMALE DATE OF BIRTH ____/____/____ SOCIAL SECURITY # _____ - _____ - _____

MARITAL STATUS _____ EMPLOYER/SCHOOL _____ OCCUPATION _____

PREFERRED LANGUAGE: ENGLISH/SPANISH RACE/ETHNICITY _____

PREFERRED COMMUNICATION METHOD(S): EMAIL POSTAL TELEPHONE TEXT

SPOUSE OR RESPONSIBLE PARTY INFORMATION

NAME _____ PATIENT IS RESPONSIBLE PARTY

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ EMPLOYER _____

SOCIAL SECURITY # _____ - _____ - _____ MALE/FEMALE DATE OF BIRTH ____/____/____

INSURANCE INFORMATION

INSURED'S NAME _____ PATIENT SPOUSE/RES PARTY

INSURED'S ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ EMPLOYER _____ MALE/FEMALE DOB ____/____/____

MEDICAL INSURANCE: _____ ID# _____ GROUP# _____

VISION INSURANCE: _____ ID# _____ GROUP# _____

OTHER INSURANCE: _____ ID# _____ GROUP# _____

I authorize the release of any medical information necessary to my family or caregivers, referring or family physicians, or to process a claim on any insurance company. I hereby assign to and authorize directly to Vestavia Eye Care, P.C. all benefits payable under such an insurance policy. I realize that the insurance benefits may not pay my entire bill and I agree to pay the difference or the entire bill if necessary. In the event of default in the payment of my charges I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court cost, if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State.

I agree that Vestavia Eye Care, P.C. and/or its agents, in order to service my account or collect monies I may owe, may contact me by telephone at any number associated with my account, including wireless telephone numbers which could incur usage charges. I also agree that I may be contacted through text messages or emails, using any email address I provide. Contact methods may include pre-recorded or artificial voice messages and/or use of automatic dialing devices.

I/we have read this disclosure and agree that Vestavia Eye Care, P.C., its employees and/or agents may contact me/us as described above.

SIGNATURE OF RESPONSIBLE PARTY

DATE

Medical and Ocular History Questionnaire

Name: _____ Date: _____

Chief Complaint/Reason for appointment today: _____

Last Eye Exam: ___/___/___ Primary Care Physician: _____ Location: _____

Medical and Ocular History: Are you pregnant and/or nursing? no yes

List all medical problems you have (i.e. diabetes, high blood pressure, etc.): _____

Are you allergic to any medications? no yes List: _____

Do you take any medications? no yes List: _____

List all ocular conditions you have been diagnosed with: _____

List all major injuries, surgeries, and/or hospitalizations you have had: _____

List all ocular surgeries you have had: _____

Social History: Do you use tobacco products? no yes Check if you have been exposed to or infected with:

Do you drink alcohol? no yes Gonorrhea HIV
Do you use any other drugs? no yes Syphilis Hepatitis

Family History: Please note any family history (parents, maternal/ paternal grandparents, siblings and/or children) for the following conditions:

	DISEASE/CONDITION	NO	YES	RELATIONSHIP TO YOU
OCULAR:	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
MEDICAL:	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Eyewear: Do you wear glasses? no yes
Do you wear contact lenses? no yes Age of current lenses: _____ Type: rigid soft

Review of Systems: Please note if you have ever had any problems in the following areas. : (use back if needed)

ALLERGY (food, etc.)	<input type="checkbox"/>	HEMATOLOGIC (anemia, etc)	<input type="checkbox"/>
CARDIOVASCULAR (heart)	<input type="checkbox"/>	IMMUNOLOGIC (allergy, lupus)	<input type="checkbox"/>
GENERAL (fever, weight loss)	<input type="checkbox"/>	INTEGUMENTARY (skin, acne)	<input type="checkbox"/>
EARS, NOSE, MOUTH, THROAT	<input type="checkbox"/>	MUSCULOSKELETAL (arthritis)	<input type="checkbox"/>
ENDOCRINE (thyroid, diabetes)	<input type="checkbox"/>	NEUROLOGIC (migraine, seizure)	<input type="checkbox"/>
GASTROINTESTINAL (ulcer, etc)	<input type="checkbox"/>	PSYCHIATRIC	<input type="checkbox"/>
GENITOURINARY (kidney, etc)	<input type="checkbox"/>	RESPIRATORY (asthma, etc)	<input type="checkbox"/>

Vestavia Eye Care, P.C.

Vision and Medical Eye Care Services

John A. Essinger, II, O.D., M.S.

James D. Fisk, O.D., Ph.D.

Calah O. Ray, O.D.

CONSENT FOR TREATMENT & FINANCIAL AGREEMENT

PATIENT'S NAME _____ DATE _____

I consent to treatment necessary or desirable to the care of the patient mentioned above, including but not restricted to, dilation drops, pharmaceutical agents, and/or surgical procedures that may be used by the attending doctor of optometry, his technician, or qualified designee.

Dilation of your eyes is necessary to obtain the best view of your retina, but can cause blurred vision and/or glare for several hours. We recommend that you do not drive for the first few hours following dilation. You may return for this dilation on another date or use our phone to call someone to pick you up. I have read this information about dilation and fully understand that driving may not be safe for me or for others. If I choose to drive after dilation, I do so at my own risk and Vestavia Eye Care, P.C. will in no way be held responsible.

I understand that the patient or responsible party is **solely responsible** for payment of all services, although the insurance carrier may be billed for said services. If this account becomes overdue, I agree to pay all reasonable costs of collection including any legal fees.

I understand that some services are not always covered by my insurance company based on the medical necessity. I understand that if any treatment is rejected by my insurance plan as a non-covered procedure, **I will be billed for those services.** I acknowledge as a member of these plans that this office will submit my insurance claim and **I will be responsible for paying all co-pays and/or deductibles at the time of the visit.**

I authorize my insurance company to remit payment of medical benefits directly to this office for services provided.

I hereby authorize the release of all medical records of the patient listed above to the referring and family physicians, as well as all necessary records for the processing of insurance claims.

Signature of Responsible Party: _____ Date: _____

Witness Signature: _____ Date: _____

Vestavia Eye Care, P.C.

Vision and Medical Eye Care Services

2531 Rocky Ridge Road Ste. 116

Vestavia Hills, AL 35243

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY STATEMENT

NAME OF PATIENT

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

RELATIONSHIP TO PATIENT

DATE

Vestavia Eye Care, P.C.

John A. Essinger, II, O.D., M.S. James D. Fisk, O.D., Ph.D. Calah O. Ray, O.D.

Your eye exam today at **VESTAVIA EYE CARE** will be either **ROUTINE** or **MEDICAL**.

A **routine exam** occurs when a patient has **no medical history or problem** that could directly affect the visual system AND has no known medical eye conditions. Our comprehensive routine exam includes a total ocular health assessment, refraction, and a prescription for glasses. **Vision insurance plans** are used for **routine exams**.

A **medical exam** occurs when a patient has a **medical problem** that could directly affect the visual system OR they have any known medical eye condition. Some examples of this include high blood pressure, diabetes, glaucoma, cataracts, and retinal issues. Insurance rules dictate that if any medical condition exists, the exam must be billed to **medical insurance** even if the patient has a separate **vision insurance** policy.

INSURANCE POLICIES

1. **Please provide our office with your current insurance information at least 24 hours before arriving to your appointment.** If you do not inform us that you have a vision plan or medical insurance before services are rendered, we will assume no coverage exists.
2. For your convenience, we will attempt to contact your insurance company to verify your benefits at our clinic prior to your initial visit.
3. We will gladly file your vision/medical insurance claim as a courtesy to you.
4. We have no control over your contract with your insurance company.
5. Because insurance policies vary greatly, we can only estimate coverage in good faith. **We at no time guarantee what your insurance will and will not cover.**

In signing this agreement you acknowledge the following:

1. Vestavia Eye Care will not back-file claims or refund fees after services are rendered due to lack of notification of vision or medical benefits (with no exceptions).
2. You are responsible to file your own claim if you discover you have vision or medical benefits after services or products are rendered.
3. You are financially responsible today for all fees. You are also financially responsible for any and all fees not collected if your insurance plan denies payment or applies it to your deductible.

How will you be paying today? Check Card Cash

Signature of Responsible Party and Consent to Treat: _____

Today's Date: _____