VESTAVIA
EYE CARE
life in focus

John A. Essinger, O.D., M.S Calah O. Ray, O.D. Hillary C. Smith, 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_____

MALE/FEMALE DATE OF BIRTH_____/_____/_____ SOCIAL SECURITY #_____-_____-_____

MARITAL STATUS _____EMPLOYER/SCHOOL_____OCCUPATION_____

PREFERRED LANGUAGE: _____ RACE/ETHNICITY _____

PREFERRED COMMUNICATION METHOD(S): □ EMAIL □ POSTAL □ TELEPHONE □ TEXT

SPOUSE OR RESPONSIBLE PARTY INFORMATION

NAME_____□ PATIENT IS RESONSIBLE 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#_____

I understand and agree that Vestavia Eye Care may contact me by telephone, text message, email, or postal service in order to service my account or collect any monies I may owe.

_____ _____

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 any 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
Do you drink alcohol? □ no □ yes
Do you use any other drugs? □ no □ yes

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	□	□	_____
	Cataract	□	□	_____
	Crossed Eyes	□	□	_____
	Glaucoma	□	□	_____
MEDICAL:	High Blood Pressure	□	□	_____
	Diabetes	□	□	_____
	Other	□	□	_____

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 you ever had any problems in the following areas:
(use back if needed)

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

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PATIENT'S NAME_____ DATE_____

Consent for Treatment

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, optometric 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 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.

Financial Agreement

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. I understand that if any treatment is rejected by my insurance plan as a non-covered procedure, **I will be billed for these services**.

I authorize my insurance company to remit payment of medical benefits directly to this office for services provided. I understand that I will be responsible for paying all co-pays and/or deductibles at the time of my visit.

Signature of Responsible Party:_____Date:_____

Witness Signature:_____Date:_____

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Acknowledgment of Notice of Privacy Practices

The law requires that Vestavia Eye Care, PC, make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

____I was given the opportunity to read, have read or had explained to me Vestavia Eye Care, PC's Notice of Privacy Practice prior to any services offered.
___ The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible

I authorize Vestavia Eye Care, PC to release my personal health information to the following individuals:

_____

_____

_____

Our office may use texts and emails to communicate with you. Although HIPAA compliant, they may not be encrypted and complete privacy cannot be guaranteed.

___ I authorize the use of text and email.
___ I do not authorize the use of text and email to communicate with me.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____/_____
Patient Signature / Date

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have the legal authority to make medical decisions for the minor and consent to such care. Please indicate any other parent, step-parent, guardian or other individual(s) authorized to make medical decisions for the minor.

_____ / _____
Representative Signature / Relationship to Patient

_____
Other individuals authorized to make legal decisions for the minor

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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,** such as VSP or EyeMed, 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 being paying today? □ **Check** □ **Card** □ **Cash**

Signature of Responsible Party and Consent to Treat: _____

Today's Date: _____