Information & Registration

Please Print Clearly

Today's Date: _____ / _____ / _____

Birthdate: _____ / _____ / _____

Patient ____
Last First M.I.

Address ____

____
City State Zip

Home Phone: ( ) ____________________

SS#: ____________________

Employer ____

Work Phone: ( ) ____________________

Employer Address ____
City State Zip

Occupation: ____________________

Sex: ☐ Male ☐ Female

Cell Phone: ( ) ____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow Spouse / Parent Name ____________________

Person Responsible for Financial Statement (Complete if patient is under 18 or a student)

Name ____ Relationship: ______________ DOB____ / ____ / ____
Last First M.I.

Address ____

____
City State Zip

Home Phone: ( ) ____________________

SS#: ____________________

Employer ____

Work Phone: ( ) ____________________

Employer Address ____
Street City State Zip

IMPORTANT

May we speak with anyone other than yourself regarding financial statements, test results, or any other services provided by our office regarding your medical treatment? ☐ Yes ☐ No If yes, who: ____________________

Emergency Contact Person ____________________ Phone: ( ) ____________________

PLEASE EXPLAIN YOUR EYE PROBLEM ____

____

Family Physician ____________________ Do you wear: ☐ Eyeglasses ☐ Contact Lenses

Please help us thank your friend or family member for introducing us to you. Were we recommended by a friend of family member?

If so, Who?: ____

Were you sent to us by a doctor who we need to update on your vision care? If so, Who?: ____________________

Insurance Information

Do you Have Routine Vision Coverage? ☐ Yes ☐ No Routine Vision Plan ____________________

ID#: ____________________ Subscriber name ____________________

Primary Medical Insurance Plan ____________________ Group #: ______________ ID#: ______________

Subscriber name: ____________________ DOB _____ / _____ / _____ SS#: ____________________

Subscriber's Place of Employment ____

Primary Medical Insurance Plan ____________________ Group #: ______________ ID#: ______________

Subscriber name: ____________________ DOB _____ / _____ / _____ SS#: ____________________

Subscriber's Place of Employment ____

Are you here for this visit due to a Work Related Injury? ☐ Yes ☐ No

Name and Phone Number of your employers Workers' Compensation Representative: ____________________

Insurance Release Form

Authorization for Treatment
While I am at the **Kansas City Eye Clinic** (**hereinafter, The Eye Clinic***), I permit the employees, the healthcare provider and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand the attending healthcare provider will explain to me the nature of my condition and his/her recommended treatment and any associated risk involved with that treatment. I also understand that they will explain to me the other ways my condition could be treated. I further understand that this care may include diagnostic testing, examinations, medical and/or surgical treatment and no guarantees have been made to me regarding the outcome of this care.

Medicare Lifetime Consent
I certify that the information given by me in applying under the Title XVII of the Social Security Act is true and correct. I authorize any holder of my medical or other information to release this information to the Social Security Administration, its intermediaries or carriers as required to support a Medicare Claim for services provided by The Eye Clinic. I authorize The Eye Clinic to submit a claim for Medicare benefits payable on my behalf. I request that payment of authorized Medicare benefits be made directly to The Eye Clinic and/or its doctors on my behalf; I assign those benefits to The Eye Clinic and/or its doctors.

All Other Insurance
Authorization is hereby granted to The Eye Clinic to release medical records and other requested information for the completion of claims to my insurance company. I further authorize payment for medical benefits to be made directly to The Eye Clinic. I understand that I am personally and financially responsible for all services provided by The Eye Clinic, unless covered by Workers' Compensation.

Signature ____________________ Date ____________________

Signature ____________________ Date ____________________

Signature ____________________ Date ____________________

Signature ____________________ Date ____________________

Signature ____________________ Date ____________________

Signature ____________________ Date ____________________

Signature ____________________ Date ____________________

Signature ____________________ Date ____________________

Signature ____________________ Date ____________________

Signature ____________________ Date ____________________

Signature ____________________ Date ____________________

(*"The Eye Clinic" refers to the Kansas City Eye Clinic, its doctors and employees where appropriate)

Clinic Financial Policy

This information has been prepared for you benefit and reference. It contains our policies regarding insurance plans, billing and payment for our services.

Please read and initial each statement in the blank provided

The Kansas City Eye clinic will file claims for primary and secondary insurance plans on your behalf. Co-payments, charges for non-covered services and deductibles are due in full at time of service. _______

It is your responsibility (and the guardian of minors' responsibility) **to be aware of and follow your insurance plan guidelines and restrictions.** You are responsible for obtaining a referral if your plan requires one. You are responsible for selecting a provider that participates with your insurance. The most up-to-date and comprehensive list of participating providers is available when you speak directly with your insurance plan; the Kansas City Eye Clinic cannot provide as up-to-date a list. You must use the information provided by your insurance company to determine if your doctor is a participating provider. _______

The Kansas City Eye Clinic does NOT file claims to automobile or liability insurance. Payment for all charges is due at the time of service. The patient will be provided with the information they need to file their own claim to the insurance company. _______

Kansas City Eye Clinic will follow-up on unpaid insurance claims. However, your insurance coverage is an agreement between you and your insurance plan and it is your responsibility to assure that services are paid. If your insurance coverage changes, delays or denials as a result of insurance information that is incomplete or not up-to-date will result in the payment for services and materials due directly from the patient. _______

Adult or teenage children who require examination, treatment, eyeglasses or lenses must have required insurance information and be prepared to pay any balance or fee not covered by insurance. _______

Routine vision plans will not cover exams when the patient has a vision or eye complaint or a medical diagnosis. These plans are generally for healthy eye exams and cannot be billed for care when there is a complaint or a medical diagnosis. _______

Most insurance companies consider a refraction *to be a non-covered service. A* refraction *is the test used to determine the power and prescription of your eyeglass or contact lenses. You are responsible for payment of the* refraction *if your insurance does not cover it.* _______

Your Social Security number is a required part of your financial information with the Kansas City Eye Clinic. This information, as with your medical record, is protected with strict confidentiality. When the Clinic does not receive full payment for all charges at the time of service, by definition, we extend credit to the patient, and consequently can appropriately ask for this information to be part of our records. Alternatively, all charges can be paid in full until insurance makes payment after which we will process a refund to the patient. ______

The Kansas City Eye Clinic will assess a charge for copies of medical records to cover the costs of processing the record. A patient will be provided 10 pages of their medical record at no charge. Additional or subsequent pages will be provided at 50 cents per page and a $10.00 processing fee per occurrence after appropriate authorizations have been made. _______

Your signature below indicates that you have read each of the requirements and advisories above, agree to and understand your obligations.

____   _________________

Patient or Financially Responsible Party   Date

KANSAS CITY
EYE
CLINIC

Patient Medical History

Name ________________________________ Date of Birth _____________ Person or Doctor Who Referred you ________________

Please check below if you have or have had any of the conditions listed:

Neurological ☐ Stroke ☐ Seizure ☐ Panic Attacks ☐ Anxiety ☐ Alzheimer's Disease ☐ Dementia
☐ Migraines ☐Other ____

Bladder/Kidney ☐ Enlarged Prostate ☐ Kidney Disease ☐ Dialysis Have you ever taken FLOMAX? ☐YES
☐ Other ____

Musculoskeletal ☐ Arthritis ☐ Degenerative Joint Disease ☐ Ankylosing Spondylitis ☐ Fibromyalgia
☐ Other ____

Endocrine ☐ Diabetes [Insulin Dependent? ☐ Yes] ☐ Thyroid Disease ☐ Graves Disease
☐ Other ____

Cardiovascular ☐ Angina ☐ Heart Attack ☐ Congestive Heart Failure ☐ High Blood Pressure ☐ High Cholesterol
☐ Atrial Fibrillation ☐ Heart Murmur ☐ Blood Clots ☐ Bleeding Tendencies
☐ Other ____

Skin ☐ Hepatitis ☐ Dry Skin ☐ Keloid Scarring ☐ Rashes ☐ Acne Rosacea ☐ Other ___________

Respiratory ☐ Short of Breath ☐ Emphysema ☐ Asthma ☐ COPD ☐ Use of Oxygen ☐ Seasonal Allergies
☐ Sleep Apnea [Use of CPAP/BiPAP Machine? ☐ YES] Other ________________________________

Auto-Immune ☐ Lupus ☐ HIV/AIDS ☐ Sarcoidosis ☐ Other ____

Cancer What kind or where? ________________________________ When were you diagnosed? ____________

Smoking _____ Pack/day Drink Alcoholic Beverages _____ Drinks/Week

Occupation ____

☐ Wear Eyeglasses ☐ Wear Contact Lenses ☐ Hearing Aids

☐ Previous Eye Surgery ☐ Previous Eye Injury ☐ Previous Trouble with anesthesia

Please Explain ____

____

Have any siblings, parents/grandparents had any of the above conditions? ____

____

Have any siblings, parents/grandparents had any EYE problems other than needing eyeglasses? ________________________

____

Your Reason for today's visit ____

Any other eye-related problems (Not already listed) ____

List any surgery you've had ____

____

Please note anything else about you that the doctor should know ___________________________________

____

Date __________ Patient Signature _________________________________ Doctor Signature ________________________

KANSAS CITY EYE CLINIC

PATIENT MEDICATION RECORD

Name ____________________________________ Date of Birth ____________

Do you take any medications? ☐ YES ☐ NO

Pleased Check, if you have ever taken:
☐ Flomax (Tamsulosin) ☐ Cardura (Doxazosin) ☐ Minipress (Prazosin) ☐ Hytrin (Terazosin) ☐ Uroxatral (Alfuzosin)

Do you have any medication ALLERGIES? ☐ YES ☐ NO If so, what medication and what reaction did you have?
____
____

Please list the medications you take, below

Medication or Supplement	**Reason Taken**	**Date Started**	