KANSAS CITY EYE CLINIC

Information & Registration

Please Print Clearly

Today's Date: _____ / _____ / _____

Patient _____ Birthdate: _____ / _____ / _____
Last First M.I.

Address _____ SS#: _____

_____ Primary Phone: ( ) _____
City State Zip

Employer _____ Secondary Phone: ( ) _____

Employer Address _____ Work Phone: ( ) _____
City State Zip

Sex: ☐ Male ☐ Female Occupation: _____ *e-mail : _____

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

Are you currently residing or being cared for by ☐ Skilled Nursing facility ☐ Inpatient Rehabilitation facility ☐ Hospice ?

*your e-mail address will be held in a secured database and will not be sold or shared with any other company or organization

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

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

Address _____ Home Phone: ( ) _____

_____ SS#: _____
City State Zip

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 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? Please give us the name of your Family physician as well?:

Dr. _____ Dr._____

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 _____

Secondary 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

There is a discretionary fee of $50 that may be assessed to the patient's account when the patient is "No Show" on their appointment date or when an appointment is not cancelled or rescheduled at least 24 hours in advance.

KANSAS CITY EYE CLINIC

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)

KANSAS CITY EYE CLINIC

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

MEDICAL HISTORY QUESTIONNAIRE

Today's Date: ___ / ___ / _____

Name: _____ Nickname: _____ Date of Birth: ___/___/_____

Primary Care Physician: _____ Referring /Specialty

Dr._____

Pharmacy:_____ **Location**(**STREET** & city)

_____

Preferred Language: □ English □ French □ Italian □ Japanese □ Portuguese
□ Russian □ Spanish

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White

Ethnicity: □ Hispanic □ Not Hispanic

Allergies: Reaction Severity

_____ _____ mild / moderate / severe

_____ _____ mild / moderate / severe

_____ _____ mild / moderate / severe

Past Ocular History: (Please mark all that apply)

□ Overall Healthy □ Cataracts □ Hyperopia (Far sighted) □ Myopia (Near sighted)
□ Amblyopia (Lazy eye) □ Diabetic Retinopathy □ Iritis □ Optic Neuritis
□ Aphakia □ Dry Eyes □ Keratoconus □ Retinal Detachment
□ Astigmatism □ Glaucoma □ Macular Degeneration

Other_____

Ocular Surgeries: (Please mark all that apply)

□ No prior ocular surgery □ Foreign Body Removal □ Punctal Plugs □ Trabeculectomy (Glaucoma surgery)
□ Blepharoplasty □ Retinal Laser Surgery □ RK
□ Cataract Surgery □ LASIK □ Strabismus Surgery □ Vitrectomy
□ Corneal Transplant □ PRK (eye muscle surgery)

Other_____

Current Medications used on or for YOUR EYES : (Please list)

_____ _____

_____ _____

_____ _____

_____ _____

Ocular Significant Illnesses: (Please mark all that apply)

□ Overall Healthy □ Herpes □ Hypothyroidism □ Sjogrens
□ AIDS □ HIV Positive □ Lupus □ Graves Disease
□ Diabetes □ Hypertension □ Multiple Sclerosis □ Hyperthyroidism
□ Rheumatoid Arthritis

Other_____

Please continue on the back side of this page →

Systemic Illnesses:

□ No history of illnesses
□ Anemia
□ Arthritis
□ Arrhythmia
□ Asthma
□ Bleeding Disorder
□ Cancer
□ Thyroid Disease
□ Congestive Heart Failure
□ COPD
□ Diabetes
□ Eczema
□ Fibromyalgia
□ Headache
□ Hearing Loss
□ Hepatitis
□ High Blood Pressure
□ High Cholesterol
□ HIV
□ Kidney Disease
□ Kidney Stones
□ Liver Disease
□ Lung Disease
□ Lupus
□ Migraine
□ Polymyalgia
□ Psychiatric Disorder
□ Skin Cancer
□ Stroke
□ Alzheimer's Disease/Dementia

Other_____

Infections: (Please mark all that apply)

□ Overall Healthy
□ Chicken Pox
□ Hepatitis A / B / C
□ Herpes Simplex
□ Herpes Zoster / Shingles
□ Histoplasmosis
□ HIV / AIDS
□ Meningitis
□ MRSA
□ Syphillis
□ Toxoplasmosis
□ Wound Infection

Other_____

General Surgeries / Operations: (Please list)

_____

_____

_____

Current Other Medications: (Please list)

Please mark with a ✓, if you have ever taken:

☐ Flomax (Tamsulosin) ☐ Cardura (Doxazosin) ☐ Minipress (Prazosin) ☐ Hytrin (Terazosin) ☐ Uroxatral (Alfuzosin) ☐ Rapaflo (silodosin)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Family History:

□ Arthritis
□ Blindness
□ Cancer
□ High Blood Pressure
□ Diabetes
□ Glaucoma
□ Heart Disease
□ Retinal Disease
□ Kidney Disease
□ Lazy Eye
□ Macular Degeneration
□ Stroke
□ TB
□ Cataracts

Please note family member with each condition _____

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ current some day smoker □ former smoker □ never smoked

Alcohol Use: □ Yes □ No If yes how much and how often? _____

Drug Use: □ Yes □ No If yes what and how often? _____

Today's Date: ___ / ___ / _____

Name: _____ Nickname: _____ Date of Birth: ___/___/_____

Review of Systems: Are your CURRENTLY EXPERIENCING any of the following (Please mark all that apply)

Eyes
- □ Previous Surgery
- □ Contact Lens
- □ Pain
- □ Double Vision
- □ Glaucoma
- □ Cataracts
- □ Macular Degeneration
- □ Dry Eyes
- □ Flashes
- □ Floaters

Ear, Nose, and Throat
- □ Hard of Hearing
- □ Ringing in Ears
- □ Vertigo

Cardiovascular
- □ Chest Pain
- □ Dizziness
- □ Fainting Spells
- □ Shortness of Breath
- □ Irregular Heart Beat
- □ Difficulty Lying Flat

Constitutional
- □ Fatigue/Weakness
- □ Fever
- □ Weight Gain/Loss

Respiratory
- □ Cough
- □ Congestion
- □ Wheezing
- □ Asthma

Gastrointestinal
- □ Heartburn
- □ Nausea / Vomiting
- □ Jaundice / Hepatitus

Genito-Urinary
- □ Pain / Difficulty
- □ Blood in Urine
- □ History of Kidney Stones
- □ History of STD's

Psychiatric
- □ Anxiety / Depression
- □ Mood Swings
- □ Difficulty Sleeping

Endocrine
- □ Increased Thirst
- □ Increased Hunger
- □ Increased Urination
- □ Increased Sweating
- □ Fingernail Changes

Blood / Lymph nodes
- □ Easy Bruising
- □ Gums Bleed Easy
- □ Prolonged Bleeding
- □ Heavy Aspirin Use

MusculoSkeletal
- □ Stiffness
- □ Arthritis
- □ Joint Pain / Swelling

Skin
- □ Rash / Sores
- □ Lesions
- □ Hives / Eczema

Neurological
- □ Seizures
- □ Weakness / Paralysis
- □ Numbness
- □ Tremors

Immunologic
- □ Hives
- □ Itching
- □ Runny Nose
- □ Sinus Pressure